

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8965 CERTIFICATE OF DEATH 08956

1. PLACE OF DEATH a. COUNTY <u>Carroll Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>54 Bond St.</u>				d. STREET ADDRESS <u>54 Bond St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDITH MAE ARMACOST</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 21 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13 1892</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Bowdoin Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George R. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Edith Adamson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>John L. Armacost, Westminster, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AMYOTROPHIC LATERAL SCLEROSIS</u> 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1</u> 19 <u>60</u> , to <u>Aug 21</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug 21</u> 19 <u>61</u> , and that death occurred at <u>9:30</u> p. m. from the causes and on the date stated above.							
22a. SIGNATURE <u>James J. Marsh</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/23/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>				22d. ADDRESS <u>WESTMINSTER MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/24/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. S. Myers, Jr., Westminster, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William L. ...</u>	

(M)

(1)

12/11/1911

12/11/1911

12/11/1911

12/11/1911

12/11/1911

12/11/1911

12/11/1911

12/11/1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1

8966

015

(M)

(I)

08957

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>lmo. 13 dys.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Trott</b> Last <b>Becraft</b>				4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1876</b>	
9. AGE (in years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield State Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with senile brain disease, with psychotic reaction.</b>							
INTERVAL BETWEEN ONSET AND DEATH Hours <b>-</b> Years <b>-</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>7-11-1961</b> to <b>8-24-1961</b> , that (I) (we) last saw the deceased alive on <b>8-24-1961</b> , and that death occurred at <b>2:30 a.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b> M.D.				22b. DATE SIGNED <b>8-24-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-26-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Oakland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>CARROLL County Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Luther H. Haight</b> ADDRESS <b>Sykesville, Md.</b>				25a. REC'D BY REGISTRAR <b>AUG 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haight</b>	

(M)

(I)

*[Faint, mostly illegible text, possibly a memorandum or report, with some visible words like "subject", "reference", and "information"]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

015

I

2

1380

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8967 CERTIFICATE OF DEATH 00958									
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville, Md.</b> c. LENGTH OF STAY IN 1b <b>60 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Md.</b> d. STREET ADDRESS <b>310 Harrison Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Mary Ellen Bohn</b>			4. DATE OF DEATH <b>Aug. 19 1961</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 2, 1897</b>		9. AGE (In years last birthday) <b>64 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Allegany, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Youngblood</b>				14. MOTHER'S MAIDEN NAME <b>Ida Appold</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT <b>Springfield State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Aspiration-Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Schizophrenic reaction, catatonic</b>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>6-20-61</b> , 19 <b>61</b> , to <b>Aug. 19</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Aug. 19</b> , 19 <b>61</b> , and that death occurred at <b>11:20 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. Naci Buyukansul</b>				22b. DATE SIGNED <b>Aug. 19, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Naci Buyukansul</b>			
22d. ADDRESS <b>Springfield State Hospital</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/23/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 24 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

1900

(M)

(J)

*[Handwritten signature]*

8  
9

H. Wayne-Gerrard, Cambridge, Mass.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2028

08959

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eldersburg</b>		c. LENGTH OF STAY IN 1b <b>2 months.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eldersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. STREET ADDRESS <b>331 W. Pabrick St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Bell</b> Last <b>Burns</b>		4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 23, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>10</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Cutsail</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Burke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Harvey C. Burns, 331 W. Patrick St. Frederick, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b> <b>same</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb.</b> 19 <b>61</b> , to <b>15 August</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>15 August</b> , 19 <b>61</b> , and that death occurred at <b>4:25 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm. H. Lawson, Jr., M.D.</b>		22b. DATE SIGNED <b>8/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. H. Lawson, Jr., M.D.</b>		22d. ADDRESS <b>Sykesville-2, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/18/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Providence Methodist Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Kemptown Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M.R. Etchison &amp; Son, 106 E. Church St, Frederick, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

CRIMINAL RECORD

Section

Division

Date

Case No.

Page

Arrested by

Arrested at

Charge

Age

Previous Record

Signature

Arrested on

Arrested by

Arrested at

Arrested by

Arrested on

Arrested at

Arrested by

Arrested on

Arrested at

Arrested by

Arrested on

Arrested at

Arrested by

Arrested on

Arrested at

Arrested by



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 22 Film 6204 9/5/61 mh

## CERTIFICATE OF DEATH

Reg. Dist. No. 08960

1. PLACE OF DEATH o. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>55 CHURCH ST.</b>		d. STREET ADDRESS <b>55 CHURCH ST</b>	
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>ROSE</b> Last <b>BYERS</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 18, 1881</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>JOHN BELL</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE FAVORITE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>CARL BYERS (son)</b>		Address <b>WESTMINSTER</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC CEREBRAL-VASCULAR DIS</b> DUE TO (c) <b>10 YEARS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>SEPT</b> , 1957, to <b>AUGUST</b> , 1961, that I last saw the deceased alive on <b>AUGUST 26, 1961</b> , and that death occurred at <b>12:45</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Daniel I. Welliver</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>19 RIDGE ROAD 8/28/61</b>	
PRINTED NAME (Type) <b>DANIEL I. WELLIVER</b>		<b>WESTMINSTER MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>August 31, 1961</b>	<b>Kriders Cemetery</b>	<b>Rural, Westminster Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. B. Myers, Jr.</b>		ADDRESS <b>Westminster, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 31 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician or hospital or funeral director, after this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be moved to the back of the certificate and filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8970

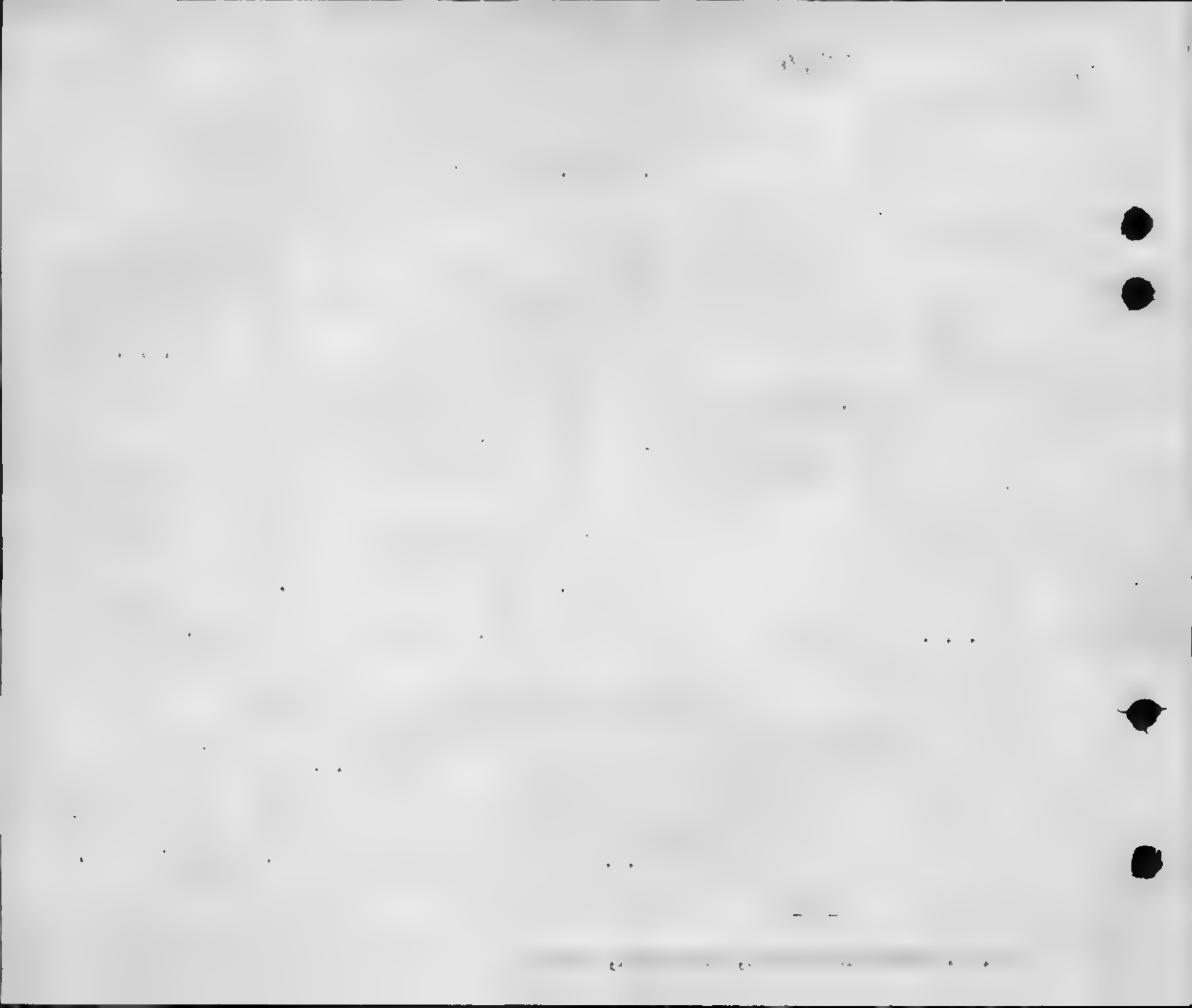
## CERTIFICATE OF DEATH

08961

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY (In days) <b>3mos.28 dys.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>701 Fairview Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Margaret Cecelia Cooney</b>		4. DATE OF DEATH Month <b>August</b>		Day <b>11</b>		Year <b>1961</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 4, 1871</b>		9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b>		Days <b>11</b>		Hours <b>19</b>		Min. <b>61</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William S. Eyerly</b>		14. MOTHER'S MAIDEN NAME <b>Maria Archer Cather</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address <b>-</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> DUE TO (b) <b>Arteriosclerotic cardiovalvular disease</b> DUE TO (c) <b>Arteriosclerosis, generalized and severe.</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>two days</b>		years <b>-</b>		years <b>-</b>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with senile brain disease, with psychotic reaction.</b>		21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		22. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		24. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		25. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		27. (City or town) <b>Springfield Hospital, Sykesville, Md.</b>		28. (County) <b>Frederick</b>		29. (State) <b>Maryland</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>4-13-1961</b> to <b>8-11-1961</b> , that (I) (we) last saw the deceased alive on <b>8-11-1961</b> , and that death occurred at <b>9:00 a.m.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>D. H. Buyukunsal, M.D.</b>		22b. DATE SIGNED <b>8-11-61</b>		23a. PHYSICIAN'S NAME (Type) <b>Naci Buyukunsal, M.D.</b>		23b. DATE THEREOF <b>8-14-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) <b>Baltimore</b>		23e. (State) <b>Maryland</b>		24. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE THEREOF <b>8-14-1961</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		24d. LOCATION (City, town or county) <b>Baltimore</b>		24e. (State) <b>Maryland</b>		25. REC'D BY REGISTRAR <b>AUG 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison and Son, Frederick, Maryland</b>		24b. ADDRESS <b>-</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		24d. LOCATION (City, town or county) <b>Baltimore</b>		24e. (State) <b>Maryland</b>		25. REC'D BY REGISTRAR <b>AUG 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		25d. LOCATION (City, town or county) <b>Baltimore</b>		25e. (State) <b>Maryland</b>		26. REC'D BY REGISTRAR <b>AUG 14 '61</b>		26b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		26c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		26d. LOCATION (City, town or county) <b>Baltimore</b>		26e. (State) <b>Maryland</b>	

M

VR A15 (4)  
15M 9/100



08962

Arthur L. Kane

V5. A15ME  
5M 7/59

TO DISCOVER MEDICAL EVIDENCE

# INVEST

s certificate sh

ould be exec

uted within 2.

4 hours after

th. If

play is neces-

# HE

1212-9-11



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08963

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>L - GRACE - DAVIDSON</u> First Middle Last		4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>FA</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-1879</u>
9. AGE (in years, last birthday) <u>81</u> yr		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William P. Hauer</u>		14. MOTHER'S MAIDEN NAME <u>Laura Ebaugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-5972R</u>	
17. INFORMANT <u>Mrs. Deland Photos</u>		Address <u>Manchester, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>120.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov</u> 19 <u>57</u> to <u>Aug 16</u> 19 <u>61</u> that I last saw the deceased alive on <u>August 16</u> 19 <u>61</u> and that death occurred at <u>8:30 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foard</u> M.D.		ADDRESS (Street, city or town, state) <u>Manchester, Md.</u> DATE SIGNED <u>8-16-61</u>	
PHYSICIAN'S NAME (Type) <u>W H. Foard M.D.</u>		<u>Manchester, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug 18-61</u>	<u>Greenmount</u>	<u>Glenn Rd Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Upton ELINE - Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Aug 22 61</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hauer</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
2  
M  
X  
I  
O  
1

8973

8973

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essexville Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>727 S. Marilyn Ave. (2)</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH</u> First Middle Last		4. DATE OF DEATH <u>Aug. 9</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1880</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Decker</u>		14. MOTHER'S MAIDEN NAME <u>Kiser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, age or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Kendrick (Same as above)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY- <u>40</u> IMMEDIATE CAUSE (a) <u>Cardiac failure, arteriosclerotic heart dis. arteriosclerosis gen.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost DUE TO (b) <u>arteriosclerosis gen.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>7-19-61</u> to <u>8-9-61</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>7-19</u> , 19 <u>61</u> , to <u>8-9</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-9</u> , 19 <u>61</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u>		22b. DATE <u>9 Aug 61</u> 22c. PHYSICIAN'S NAME (Type)	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Essexville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8-12-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Connelley</u>		25a. REC'D BY REGISTRAR <u>418 Eastern Blvd.</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	
DATE <u>AUG 11 '61</u>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8974

## CERTIFICATE OF DEATH

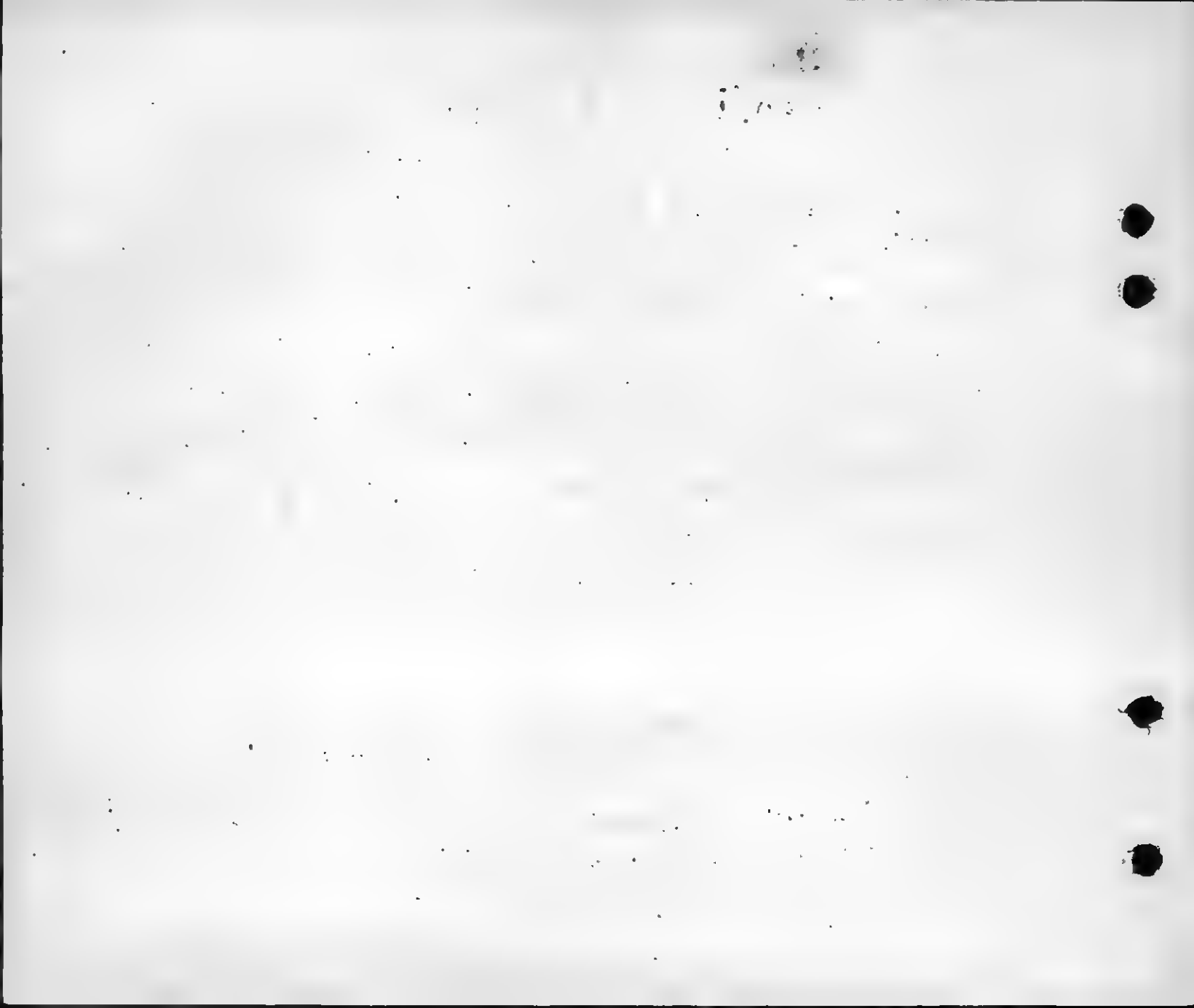
Reg. Dist. No. 8965

M	1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>	
	c. LENGTH OF STAY IN 1b <b>64 YEARS</b>			
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>81 W. GREEN ST</b>		d. STREET ADDRESS <b>81 W. GREEN ST.</b>	
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
I	3. NAME OF DECEASED (Type or print) <b>MARY HELEN</b> <b>ELDERDICE</b>		4. DATE OF DEATH <b>AUGUST 27 1961</b>	
	5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>SEPT 1896</b> 9. AGE (In years last birthday) <b>64</b> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
	13. FATHER'S NAME <b>HARRY D. FOWBLE</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE SMITH</b>	
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
	17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MALIGNANCY IN ABDOMEN</b> DUE TO <b>ETIOLOGY?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>FATTY INFILTRATION LIVER</b> DUE TO (c) <b>DIABETES MELLITUS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 MONTHS</b> <b>2 YEARS</b> <b>12 YEARS</b>	
MEDICAL CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
	21. I certify that I attended the deceased from <b>AUGUST 19, 1961</b> to <b>AUGUST 26, 1961</b> , that I last saw the deceased alive on <b>AUGUST 26, 1961</b> , and that death occurred at <b>8:30 A. M.</b> from the causes and on the date stated above.			
	ACTUAL SIGNATURE <b>Daniel J. Welliver</b> M.D.		ADDRESS (Street, city or town, state) <b>19 RIDGE ROAD</b> DATE SIGNED <b>8/27/61</b>	
	PHYSICIAN'S NAME (Type) <b>DANIEL J. WELLIVER</b>		<b>WESTMINSTER MARYLAND</b>	
	22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
	<b>Burial</b>	<b>Aug 29, 1961</b>	<b>Pope Creek Cemetery, Westminster, Md.</b>	
	23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Ziegler, Jr.</b>		24a. REC'D BY REGISTRAR <b>AUG 31 '61</b> 24b. REGISTRAR'S SIGNATURE <b>O. L. S. King</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/58



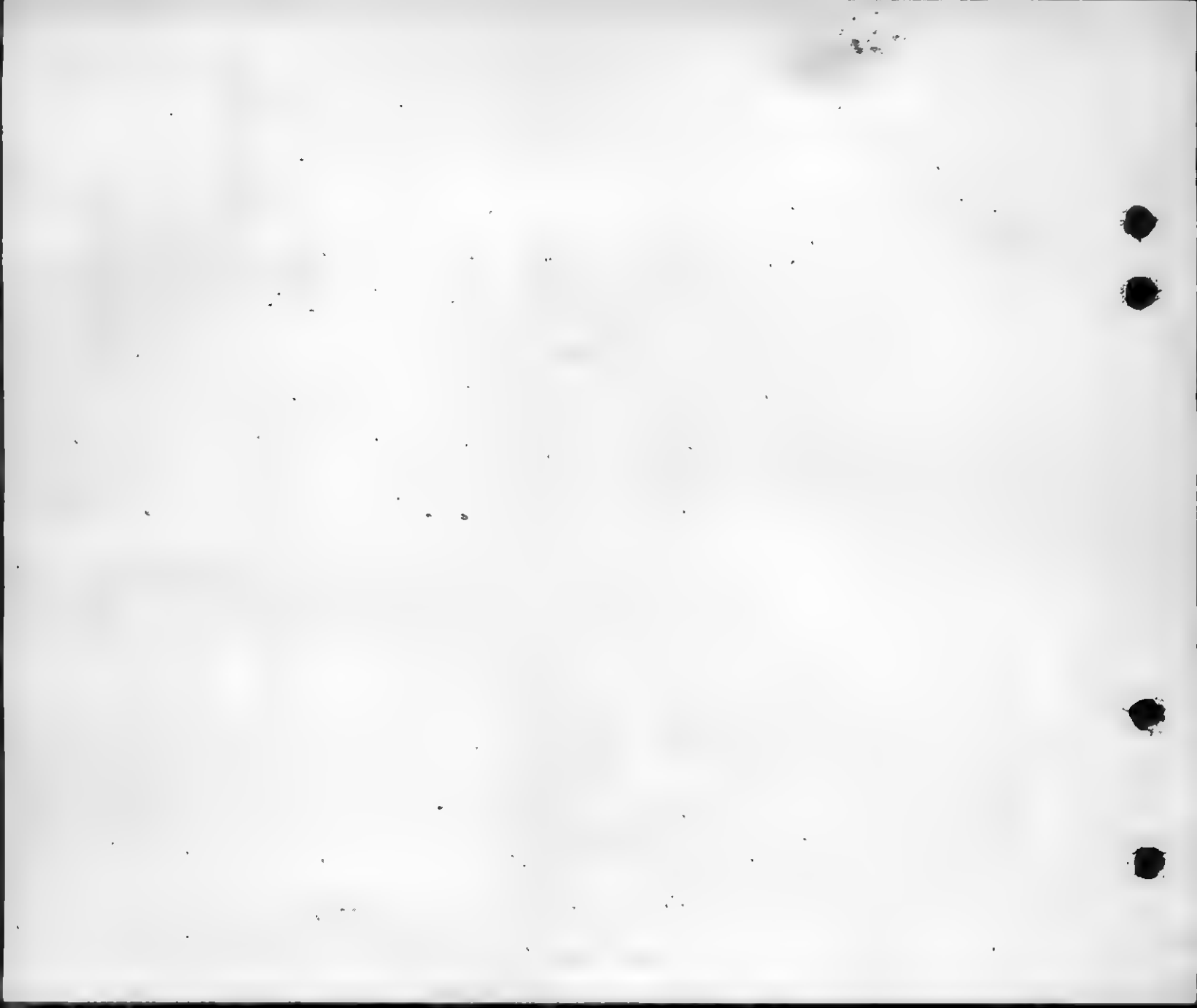


8975

CERTIFICATE OF DEATH

Reg. Dist. No. 08966

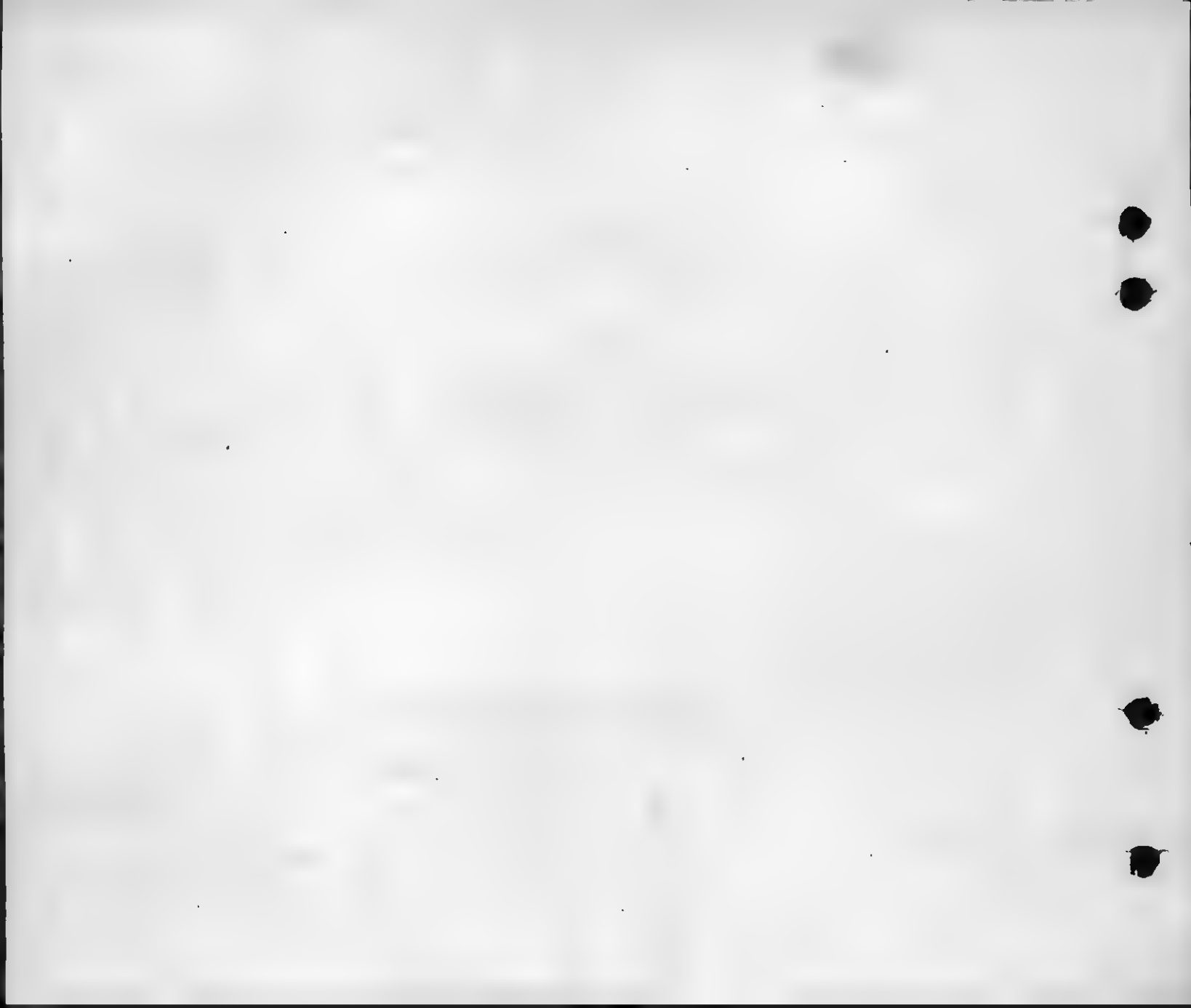
1 PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER RURAL</b> c. LENGTH OF STAY IN 1b <b>4 MONTHS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEADOWVIEW NURSING HOME</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b> d. STREET ADDRESS <b>P. MAIN STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type in full) First <b>BLANCHE</b> Middle <b>ENGLAR</b> Last <b>ENGLAR</b>		4. DATE OF DEATH <b>August 11, 1961</b> Age (In years last birthday) <b>81</b> yes <b>81</b> no <b>81</b> IF UNDER 1 YEAR Months Days Hours Min.	
5 SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>NOV 22 - 1879</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN M MOONS</b>		14. MOTHER'S MAIDEN NAME <b>MISSOURI HANN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis (cor)</b> DUE TO <b>Myocarditis (cor)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis (cor)</b> DUE TO <b>Myocarditis (cor)</b> (c) <b>Myocarditis (cor)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1953</b> to <b>Aug 12 - 1961</b> , that I last saw the deceased alive on <b>Aug 11 1961</b> , and that death occurred at <b>8:25 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm C. Jennette</b> M.D.		DATE SIGNED <b>8-12-61</b>	
PHYSICIAN'S NAME (Type) <b>Wm C. JENNETTE M.D.</b>		<b>WESTMINSTER MD</b>	
22a. BURIAL, CREMAT., ON, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG 14 - 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK</b>		22d. LOCATION (City, town, or county) (State) <b>CARROLL CO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.D. Hartzler &amp; Sons</b>		ADDRESS <b>Two Windsor</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8976  
CERTIFICATE OF DEATH  
08967

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>MARY MAY GASSMAN</u> First Middle Last		4. DATE OF DEATH <u>Aug. 9</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 4, 1877</u>
9 AGE (in years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Bell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bellison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Wilbur Hawthorne - Sykesville, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cordean failure, arteriosclerotic</u> <u>420</u> DUE TO (b) <u>heart dis, heart block, arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1960</u> <u>to</u> <u>9 Aug 61</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>1960</u> 19 <u>61</u> , to <u>9 Aug</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9 Aug</u> 19 <u>61</u> , and that death occurred on <u>9 Aug</u> 19 <u>61</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Howard E. Hall</u> M.D.		22b. DATE SIGNED <u>9 Aug 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		22d. ADDRESS <u>Sykesville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8-11-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Church of God</u>	23d. LOCATION (City, town, or county) (State) <u>Winfield Carroll Co, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u> ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>Aug 15 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

MEDICAL CERTIFICATION









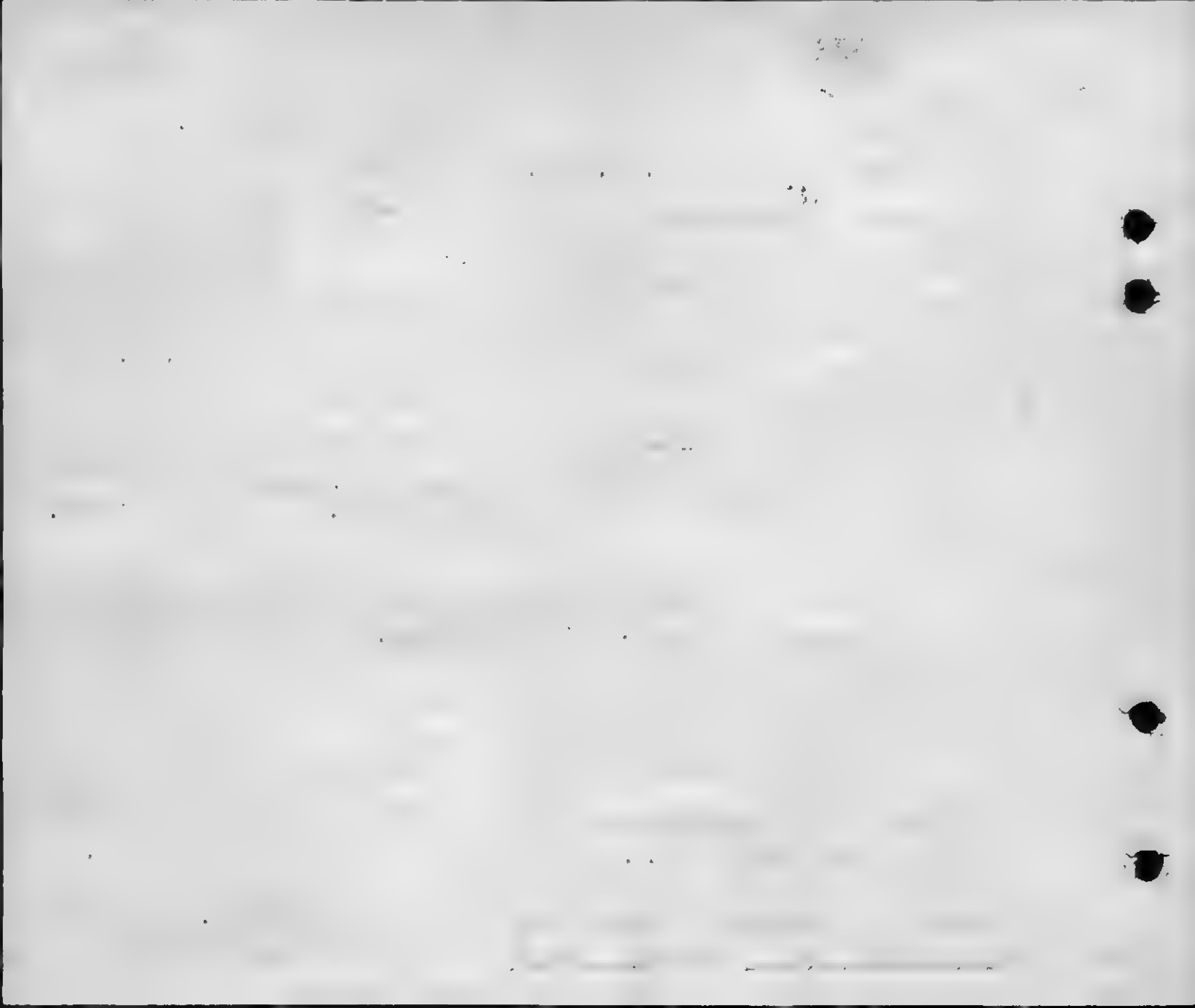
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be filed with the hospital or attending physician. The law also requires that the death certificate be filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

08969

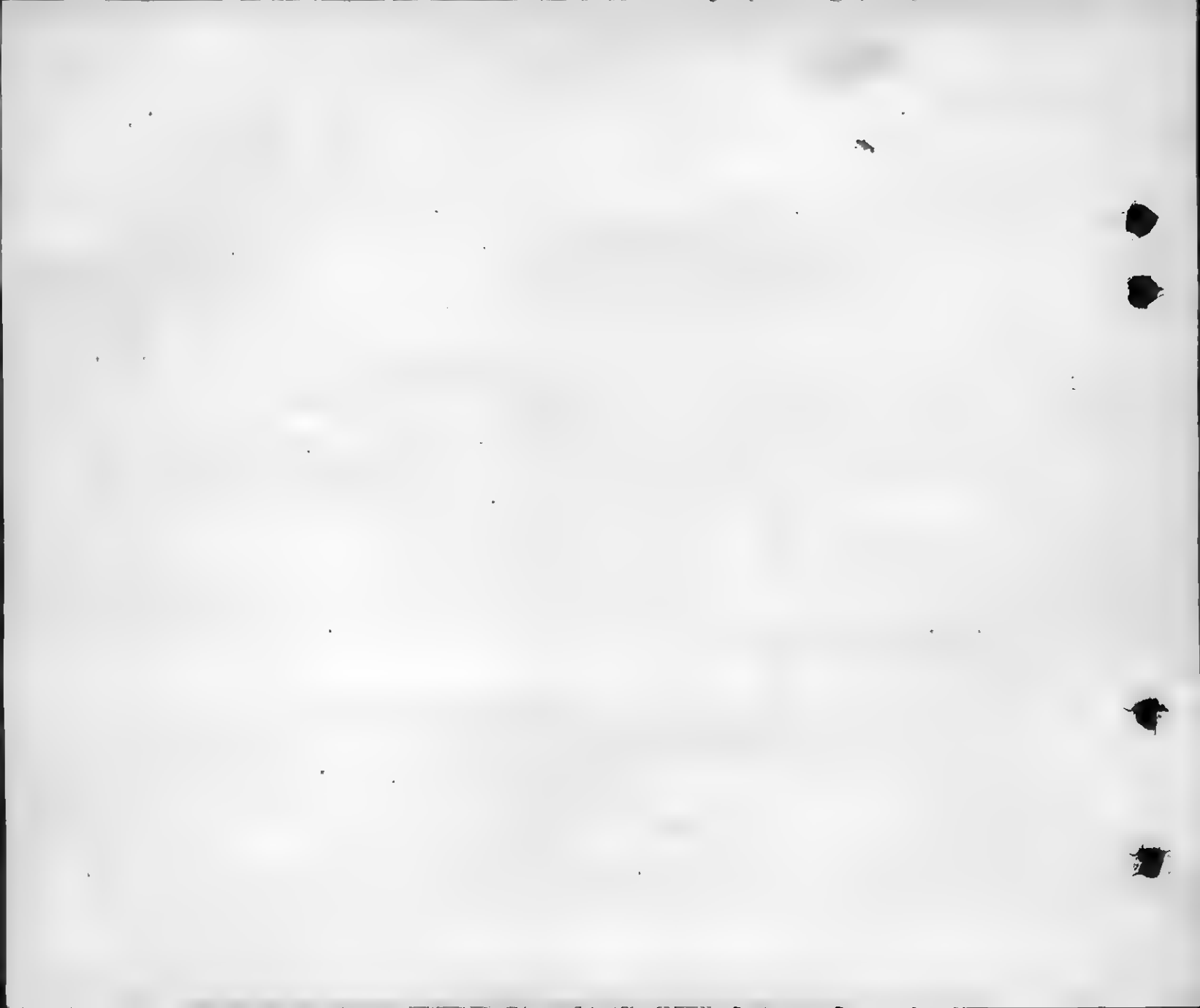
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>5yrs.2mo.14dys.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 6</b> d. STREET ADDRESS <b>5906 Cedonia Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Helen Theodora Greller</b>		<b>4. DATE DEATH</b> Month <b>August</b> Day <b>9</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>November 28-1908</b>
<b>9. AGE</b> (In years, last birthday) <b>52 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Joseph Honacki</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Frances Modrak</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-16-8932</b>	
<b>17. INFORMANT</b> <b>Springfield Hospital Records</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction, cause unknown, possibly spasm of coronary arteries.</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>Involutional psychotic reaction. Diabetes Mellitus.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involutional psychotic reaction. Diabetes Mellitus.</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town, County, State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>5-25-1956</b> , to <b>8-9-1961</b> , that (I) (we) last saw the deceased alive on <b>8-9-1961</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Naci Buyukunsal, M.D.</b> <b>22c. PHYSICIAN'S NAME (Type)</b>			
<b>22b. DATE SIGNED</b> <b>8-9-61</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			
<b>23b. DATE THEREOF</b> <b>8-14-1961</b>			
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Gardens of Faith</b>			
<b>23d. LOCATION (City, town or county, State)</b> <b>Baltimore Co. Maryland</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Lossalor Funeral Home</b>			
<b>24b. ADDRESS</b> <b>7401 Belair Road</b>			
<b>25a. REC'D BY REGISTRAR</b> <b>AUG 14 '61</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kline</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8979  
CERTIFICATE OF DEATH  
08970

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>22 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 22</b>	
f. STREET ADDRESS <b>400 Bayside Drive</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Shultz</b> Last <b>Grumbach</b>		4. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 5, 1896</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>10</b> Hours <b>10</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Shultz</b>		14. MOTHER'S MAIDEN NAME <b>Celia Snider</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address <b>-</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Acute pulmonary embolism</b> (b) <b>-</b> (c) <b>-</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b> <b>Minutes</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>11:10</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>8.m.</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-28-1961</b> to <b>8-20-1961</b> , that (I) (we) last saw the deceased alive on <b>8-20-19 61</b> and that death occurred at <b>11:10</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Agustin del Campo M.D.</b> M.D.		22b. DATE SIGNED <b>8-20-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>8-24-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge</b>		23d. LOCATION (City, town, or county) (State) <b>Dorsey, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Homes, Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 23 '61</b>	
ADDRESS <b>-</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hand</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08971

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PULLEN NURSING HOME</u>		d. STREET ADDRESS <u>8746 LACKAWANNA AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSALIE REBECCA HALBERT</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 6, 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 7, 1889</u>
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>WILLIAM H. BUCK</u>		14. MOTHER'S MAIDEN NAME <u>SARAH JANE JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>FAMILY RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor. dea. failure, arteriosclerosis.</u> 450 p. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic brain syndrome, fractured left</u> DUE TO (c) <u>hip (injured) decubiti, arteriosclerosis.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 April 57</u> <u>6 Aug 61</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>18 April, 1957</u> , to <u>6 Aug 1961</u> , that I last saw the deceased alive on <u>6 Aug 1961</u> , and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward E. Hall</u> M.D. <u>Spesville, Md.</u>		DATE SIGNED <u>6 Aug 61</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG. 8, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>PIKESVILLE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Jones</u> ADDRESS <u>Towson, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 10 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton E. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Page 1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician, the funeral director, or the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

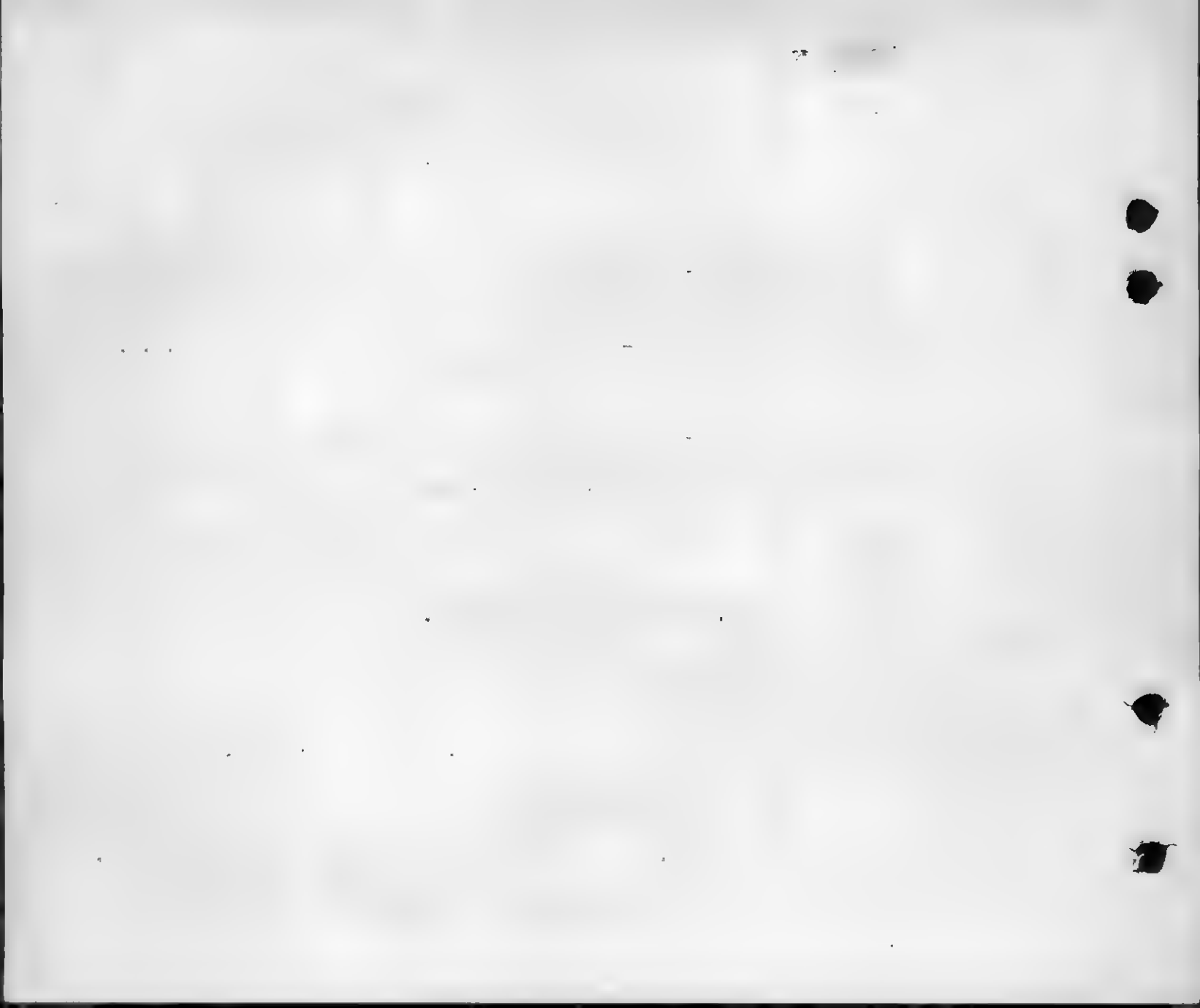
VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8981

08972

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>21 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>	
d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Norman</b> Middle <b>Jacob</b> Last <b>Hape</b>		4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>1961</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1893</b>
9 AGE (In years last birthday) <b>68</b> yrs		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Hape</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Ann Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>220-03 6466</b>	
17 INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple arterial occlusions</b> 42 2.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Chronic Brain Syndrome. Pulmonary tuberculosis.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>August 2, 1961</b> to <b>August 23, 1961</b> , that (I) (we) last saw the deceased alive on <b>August 23, 1961</b> , and that death occurred at <b>1 PM</b> from the causes and on the date stated above			
22a SIGNATURE <b>Agustin del Campo, M.D.</b>		22b. DATE SIGNED <b>8/23/61</b>	
22c PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a BURIAL OR CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/26/61</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Evergreen Mem. Garden, Salisbury, Md.</b>		23d LOCATION (City, town, or county) (State)	
24 FUNERAL DIRECTOR'S SIGNATURE <b>J. S. Myers, Jr., Funeral Director, Md.</b>		25a REC'D BY REGISTRAR <b>AUG 28 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Myers</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

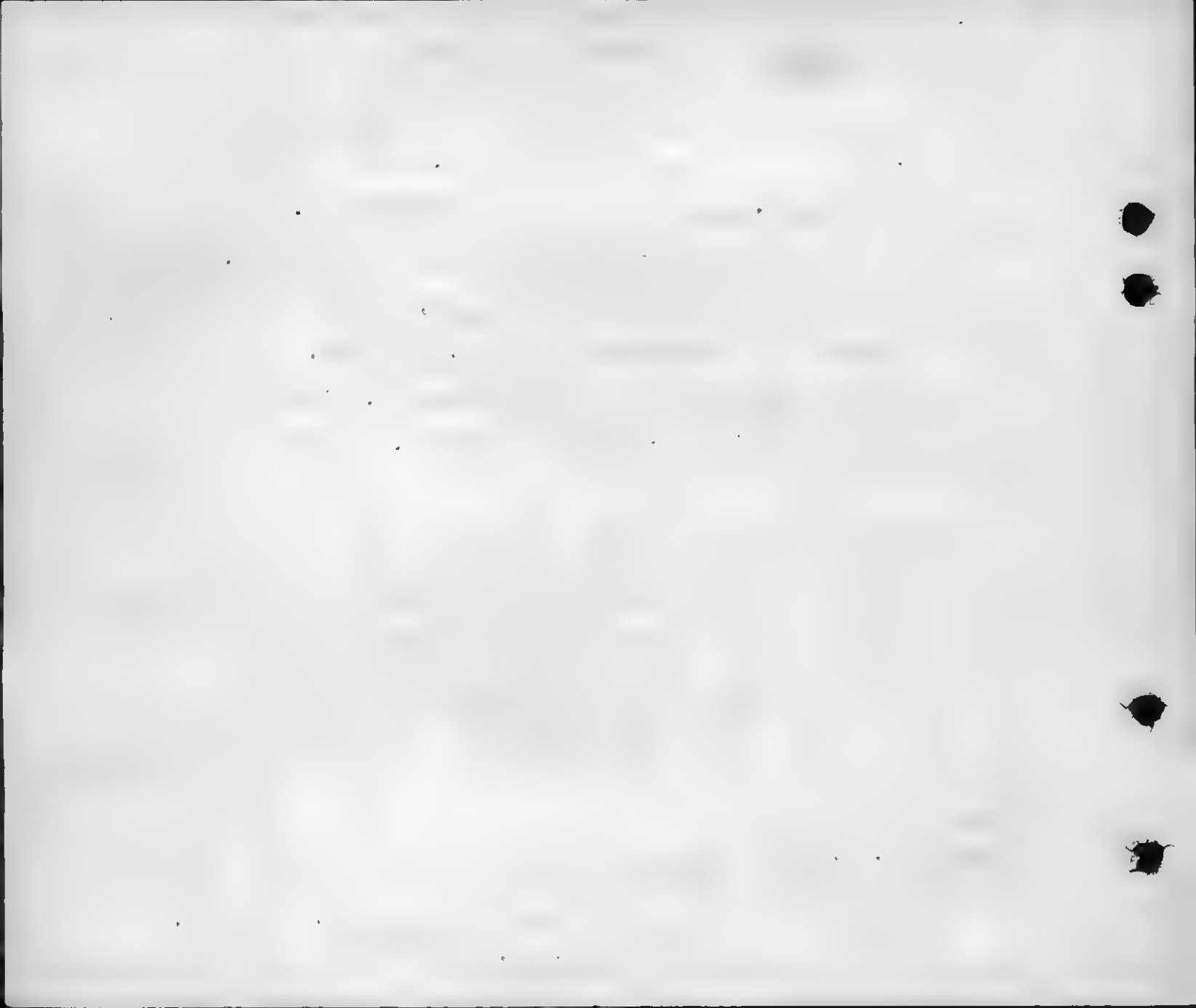
## CERTIFICATE OF DEATH

Reg. Dist. No. 08923

8982

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Ave.</b>		d. STREET ADDRESS <b>Paradise Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Leroy</b> Middle <b>-</b> Last <b>Harrison</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>16</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1906</b>
9. AGE (In years last birthday) <b>55</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Track foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Mt. Airy, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Oliver R. Harrison</b>		14. MOTHER'S MAIDEN NAME <b>Clara E. Rider</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-1596</b>	
17. INFORMANT <b>Mrs Mabel E. Harrison</b>		Address <b>Item 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4214</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chr. Endocarditis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>1 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 16, 1961</b> , to <b>Aug 16, 1961</b> , that I last saw the deceased alive on <b>Aug 16, 1961</b> , and that death occurred at <b>9 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. M. VanPoole</b>		ADDRESS (Street, city or town, state) <b>Mt. Airy, Md.</b>	
PHYSICIAN'S NAME (Type) <b>C. M. VanPoole</b>		DATE SIGNED <b>8-17-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/19/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove</b>	22d. LOCATION (City, town, or county) (State) <b>Mt. Airy, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas L. McPherson</b>		ADDRESS <b>Damascus, Md.</b>	
24a. REG'D BY REGISTRAR <b>21 61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

TO HOSPITALS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be filled by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**8983**

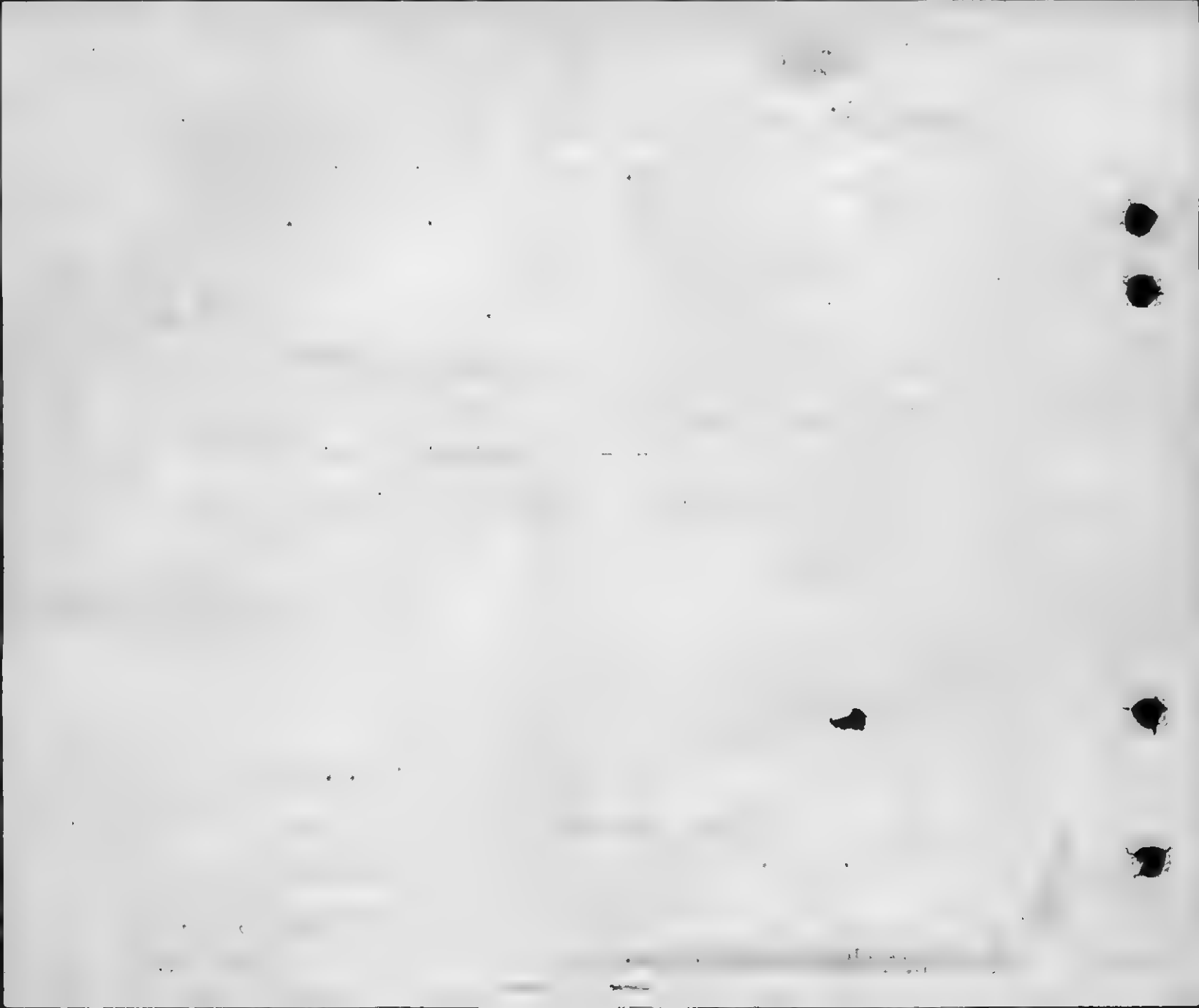
## CERTIFICATE OF DEATH

48974

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>5 Yrs. 1 Month</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>1100 E. Hoffman St.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>James</u>		<b>4. DATE OF DEATH</b> <u>August 19 1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>			
<b>10e. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Shipyard Worker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Shipyard Worker</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Austria (Hungary)</u>			
<b>13. FATHER'S NAME</b> <u>Havlik, James</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie ??</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Austria</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>?</u>				<b>16. SOCIAL SECURITY NO.</b> <u>215-09-4832</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Tuberculosis, Far Advanced.</u> (b) <u>00+X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Years</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>7/20/56</u> <b>19</b> <b>to</b> <u>8/19</u> <b>19</b> <b>that (I) (we) last saw the deceased alive on</b> <u>8/19</u> <b>19</b> <b>and that death occurred at</b> <u>8:30 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Dr. Naci H. Buyukensal</u> M.D.				<b>22b. DATE SIGNED</b> <u>August 19, 61</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. Naci H. Buyukensal</u>				<b>22d. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, REMOVAL, (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>8/22/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Holy Redeemer Cem.</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Baltimore Md.</u>		<b>(State)</b>		<b>25a. REC'D BY REGISTRAR</b> <u>AUG 22 '61</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Schimunek Funeral Home, Inc.</u> <u>2001 E. Madison St.</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



1  
M  
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the hospital or attending physician, if the death occurred in the hospital or at the home of the deceased, sign the certificate. The law also requires that the funeral director, after this certificate has been signed by the attending physician, completely fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

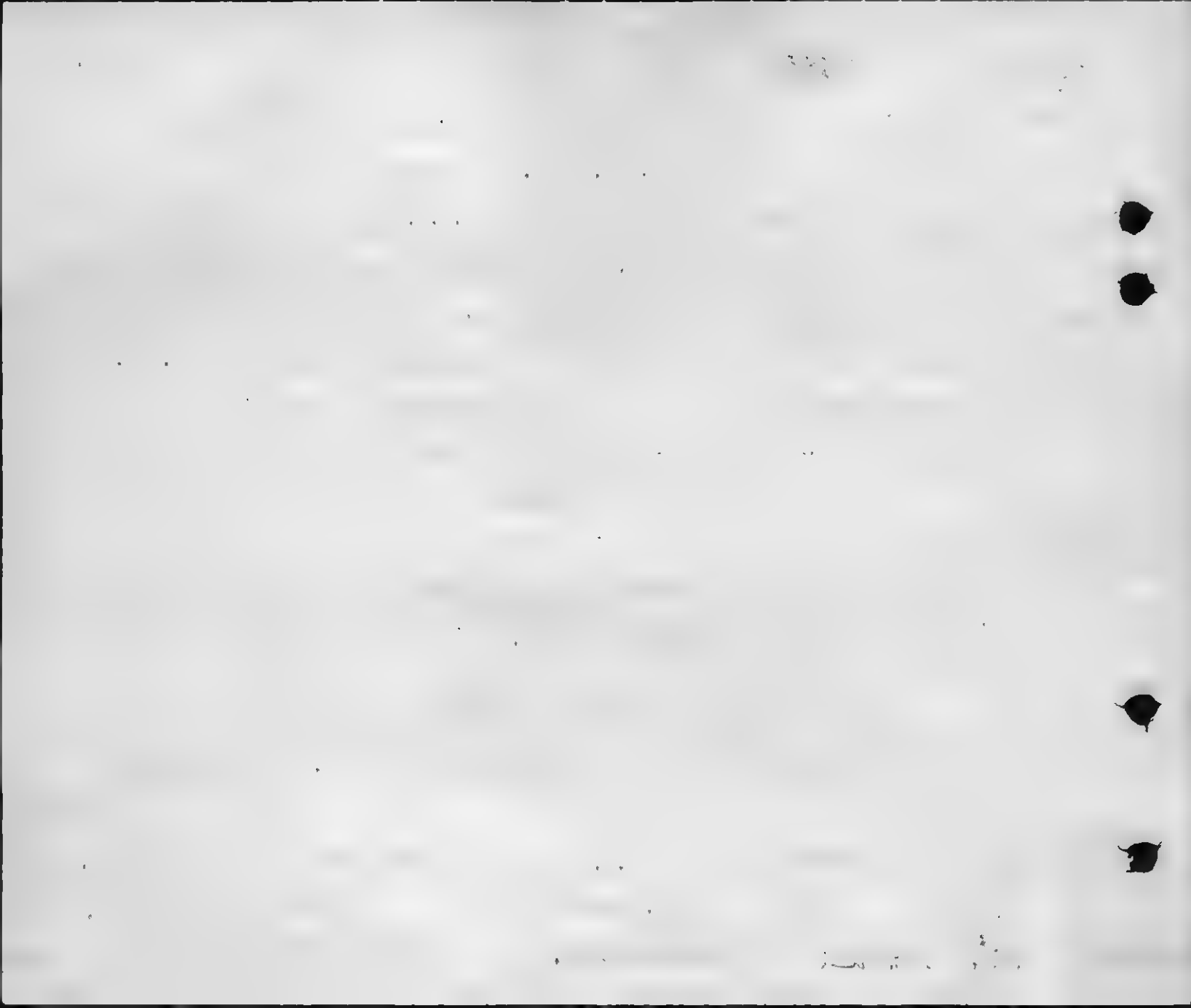
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8984

## CERTIFICATE OF DEATH

08975

1. PLACE OF DEATH e. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>8yrs. 2mo. 13days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Millrun</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>R.F.D. #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ada B. Heylman</b>		4. DATE OF DEATH <b>August 2 19 61</b>		5. AGE (In years last birthday) <b>72 yrs.</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		9. DATE OF BIRTH <b>May 28, 1889</b>		10. IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Heylman</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Hollemaid</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Pulmonary infarcts</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Auricular fibrillation</b> (c) <b>Arteriosclerotic heart disease</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with circulatory disturbance, other than cerebral arteriosclerosis, with psychotic reaction.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Unknown</b> <b>Years</b>		19. WAS A AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-19-1953</b> to <b>8-2-1961</b> , that (I) (we) last saw the deceased alive on <b>8-2-1961</b> , and that death occurred at <b>1:20 a.m.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Julian Radzykewycz, M.D.</b>		22b. DATE SIGNED <b>8-2-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Julian Radzykewycz, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/5/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>	
23d. LOCATION (City, town or county) <b>Westernport</b>		23e. (State) <b>Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. B. B. B.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. B. B. B.</b>		24b. ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 7 1961</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur J. Wright</b>		25c. DATE <b>AUG 7 1961</b>		25d. REGISTRAR'S SIGNATURE <b>Arthur J. Wright</b>	

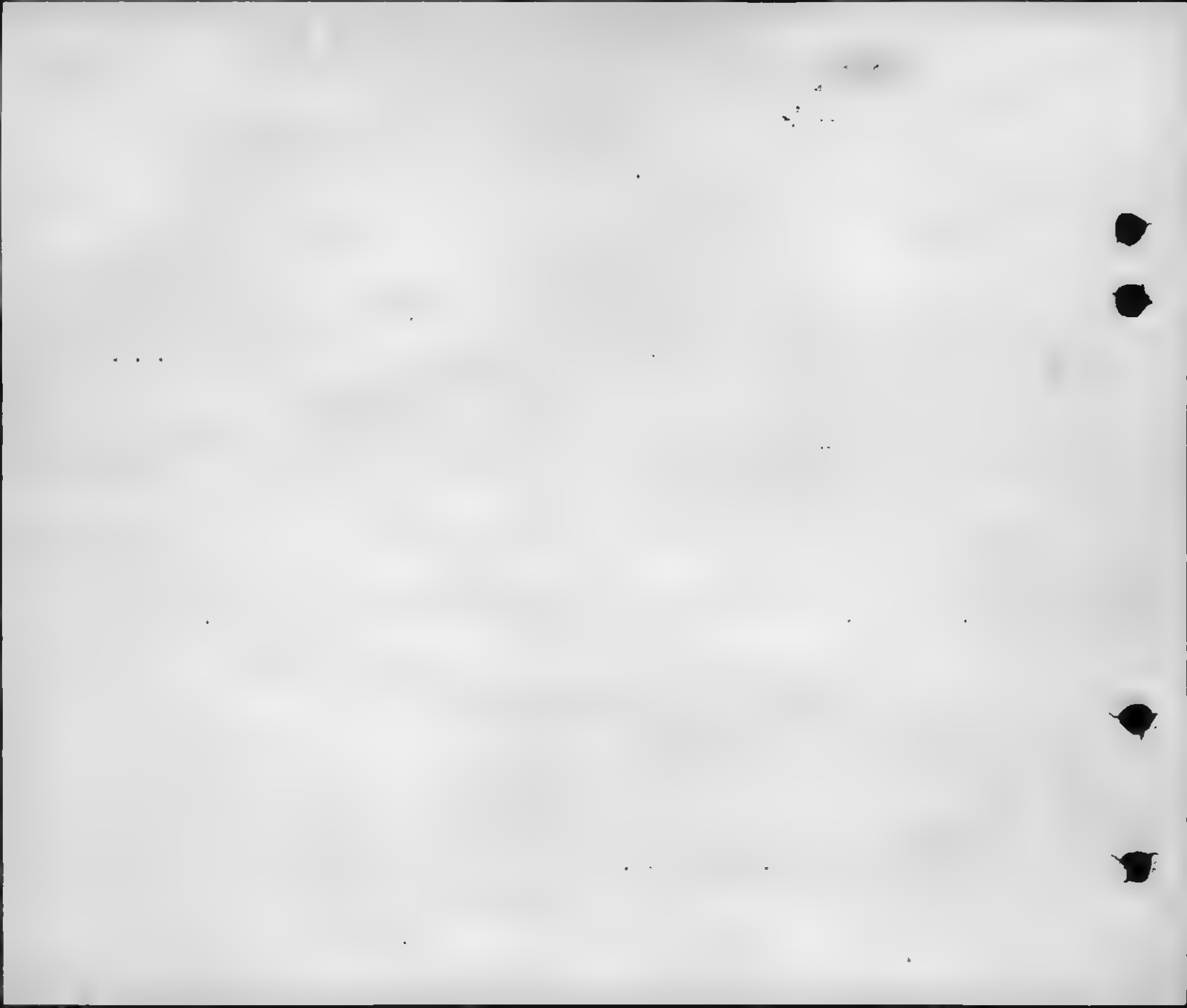


1  
FOR STATE  
HEALTH DEPT.  
M

TO DIRECTOR: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MAYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
8985 08976									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				
c. LENGTH OF STAY IN lb <u>1 mo., 8 days</u>					d. STREET ADDRESS <u>R#4, Christine Road</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Allie Beatrice Booher</u>					4. DATE OF DEATH <u>August 28, 1961</u>				
5. SEX <u>Female</u>					6. CO. OR OR RACE <u>White</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>April 26, 1891</u>				
9. AGE (In years last birthday) <u>70</u> yrs.					10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>				
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Frank Booher</u>					14. MOTHER'S MAIDEN NAME <u>Amanda Heckenberry</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>				
17. INFORMANT <u>Springfield Hospital Records</u>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>									
DUE TO									
(b) <u>Arteriosclerotic heart disease</u>									
DUE TO									
(c) <u>Generalized arteriosclerosis</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</u>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Free while being put in chair</u>									
20c. TIME OF INJURY Month, Day, Year <u>8-7-1961</u>									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>S.S.H.</u>									
20f. (City or town) (County) (State) <u>Sykesville</u> <u>Conroe</u> <u>MD</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DATE SIGNED <u>8/28/61</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
22b. DATE THEREOF <u>8/31/61</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>									
22d. LOCATION (City, town, or country) (State) <u>Cumberland</u> <u>Maryland</u>									
23. FUNERAL DIRECTOR <u>Ruth E. Silcox</u> <u>Cumberland</u> <u>Maryland</u>									
24a. REC'D BY REGISTRAR <u>SEP 5 '61</u>									
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

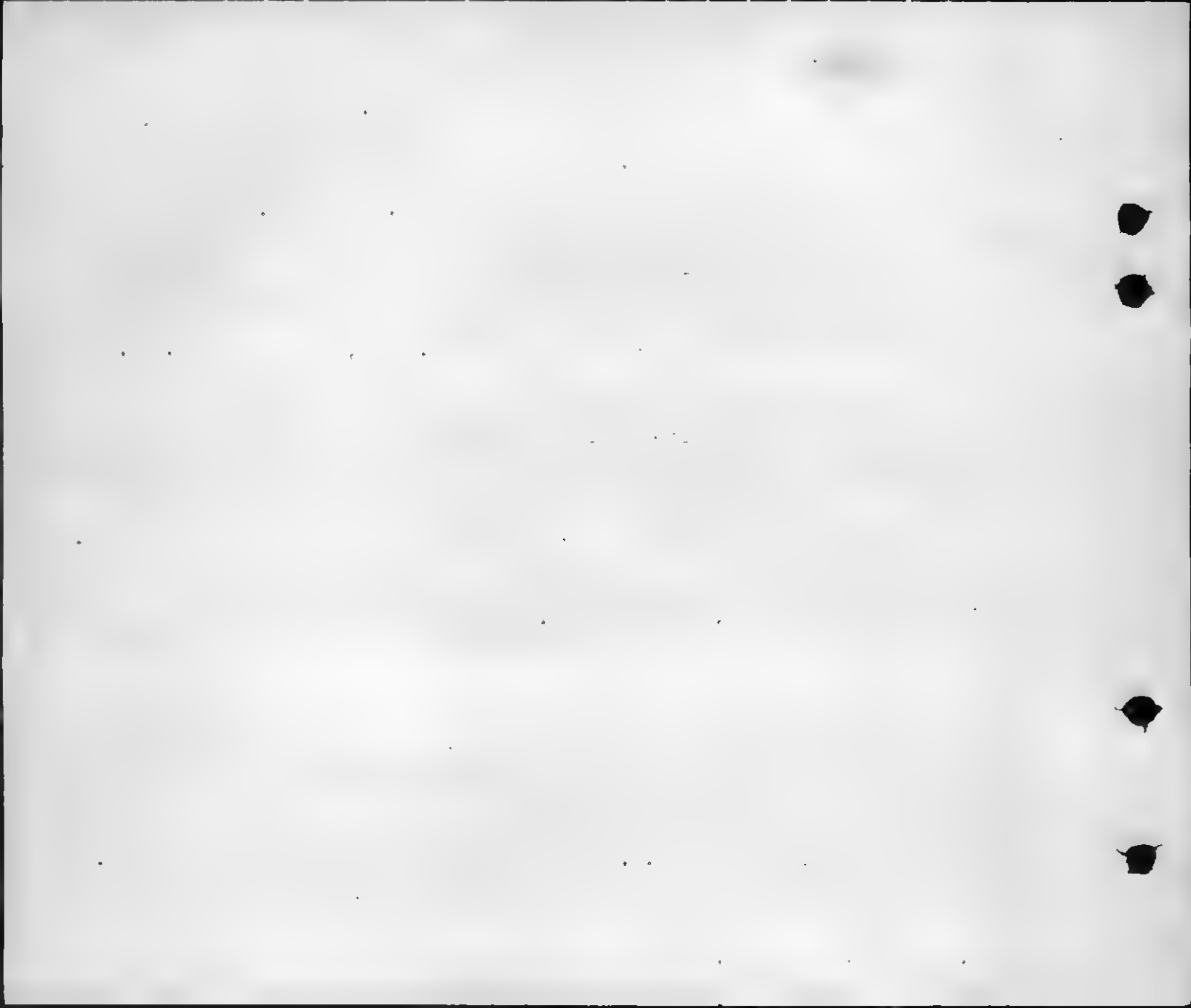
8986

08977

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN lb <b>10mos.5days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2050 E. Fayette St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Rudolph</b> Middle <b>Junker</b> Last <b>Junker</b>		4. DATE OF DEATH Month <b>August</b> Day <b>23,</b> Year <b>19 61</b>						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 5, 1890</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b>70</b>	IF UNDER 24 HRS Days <b>70</b>	Hours <b>70</b>	Min <b>70</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printing plant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Rudolph Junker</b>				14. MOTHER'S MAIDEN NAME <b>- Miller</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>218-12-7634-A</b>		17. INFORMANT <b>Springfield Hospital Records</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gangrene of legs</b> DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Schizophrenic reaction, paranoid type.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Years.</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b> (County) <b>Baltimore</b> (State) <b>Baltimore</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>October 18, 1960</b> to <b>August 23, 1961</b> , that (I) (we) last saw the deceased alive on <b>August 23, 1961</b> , and that death occurred at <b>4:20 PM</b> from the causes and on the date stated above								
22a. SIGNATURE <b>Agustin del Campo</b> M.D.		22b. DATE <b>8/23/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>		
23a. BURIAL CREMATION <b>BURIAL</b>		23b. DATE THEREOF <b>8-26-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town, or county) <b>Baltimore</b> (State) <b>Baltimore</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>				25a. REC'D BY REGISTRAR <b>AUG 28 '61</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>		

M

I



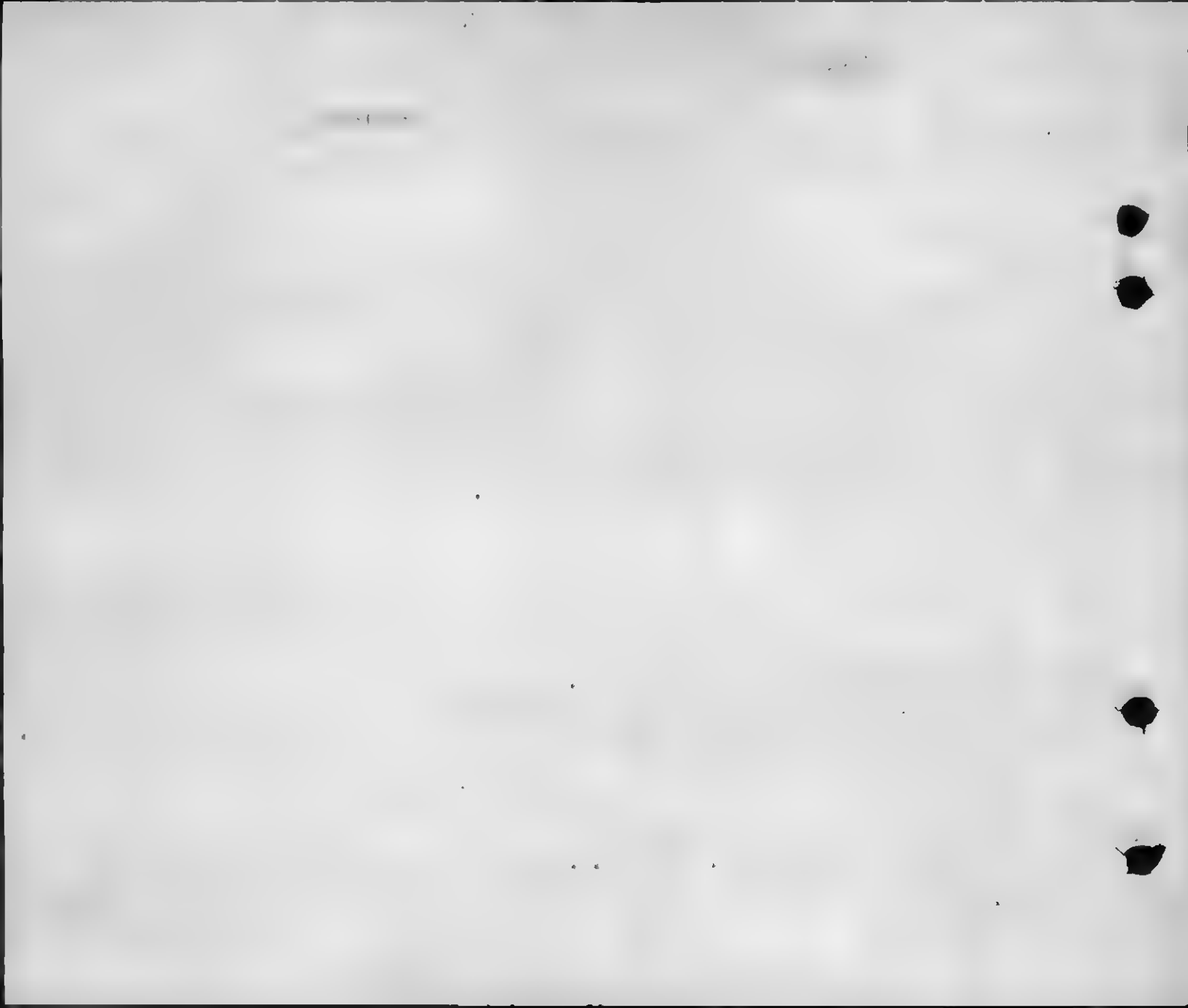
TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any, is necessary, and if any is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8987 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08978											
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Miller's Station</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Carrollton</b> d. STREET ADDRESS <b>1</b>					
3. NAME OF DECEASED (Type or print) First <b>BEVERLY</b> Middle <b>E</b> Last <b>KOCHER</b>						4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 10 - 1942</b>		9. AGE (in years last birthday) <b>19</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry F Kocher</b>						14. MOTHER'S MAIDEN NAME <b>Bettie Bye</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>No</b>					
17. INFORMANT <b>Henry F Kocher, Carrollton Md</b>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound of Head.</b> DUE TO (b) <b>981X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot in head.</b>							
20c. TIME OF INJURY Hour <b>9:00</b> p.m. Month, Day, Year <b>8/5 19 61</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Parked auto</b>			
20f. (City or town) <b>Miller's Station</b>				20g. (County) <b>Carroll</b>				20h. (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Charles S. Patty</b> EXAMINER'S NAME (Type) <b>Charles S. Patty, M.D.</b>						DATE SIGNED <b>8/6/61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8-8-61</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Hampstead</b>			
22d. LOCATION (City, town, or country) <b>Carroll Co Md</b>				22e. (State) <b>Md</b>				22f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			
23. FUNERAL DIRECTOR <b>Hipton-Elmer</b>				23a. ADDRESS <b>Hampstead Md</b>				24b. REC'D BY REGISTRAR DATE <b>AUG 9 '61</b>			

M

I



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

1  
FOR STATE  
HEALTH DEPT.

M

01

I

MEDICAL CERTIFICATION

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

22a. BURIAL CREMATION  
REMOVAL (Specify)

23. FUNERAL DIRECTOR

1. PLACE OF DEATH

a. COUNTY

Carroll

b. CITY OR TOWN (if outside corporate limits,  
write RURAL and give nearest town)

Sykesville

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Springfield State Hospital

3. NAME OF  
DECEASED  
(Type or print)

First

Joseph

Middle

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

August 27, 1904

9. AGE (In years  
last birthday)

56 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Brewery

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Lex

14. MOTHER'S MAIDEN NAME

Theresa Woodsanger

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Springfield Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Pulmonary Embolism, source unknown.

INTERVAL BETWEEN  
ONSET AND DEATH

Minutes.

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO

(b) Subdural hematoma due to skull fracture

DUE TO

(c)

10 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

C.B.S. associated with Convulsive Disorder without qualifying phrase.

2Db. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☒  
CAUSE OF DEATH.

2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Pt. had seizure, struck head on floor.

19. WAS AUTOPSY  
PERFORMED?

YES ☒ NO ☐

20c. TIME OF INJURY

Month, Day, Year

8-8- 19 61

20d. INJURY OCCURRED

While ☐ Not While ☒  
at work at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

Hospital

20f. (City or town)

Sykesville

(County)

Carroll

(State)

Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☒. Inquiry ☒. and in my opinion  
death resulted from Natural causes ☐. Accident ☒. Suicide ☐. Homicide ☐. Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

8-17-61

Address (Street, city, town, or county)

Westminster, Md.

22a. BURIAL CREMATION  
REMOVAL (Specify)

22b. DATE THEREOF

8-21-61

22c. NAME OF CEMETERY OR CREMATORY

U of Md. Med School

22d. LOCATION (City, town, or country)

Baltimore

(State)

23. FUNERAL DIRECTOR

ADDRESS

Reese

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

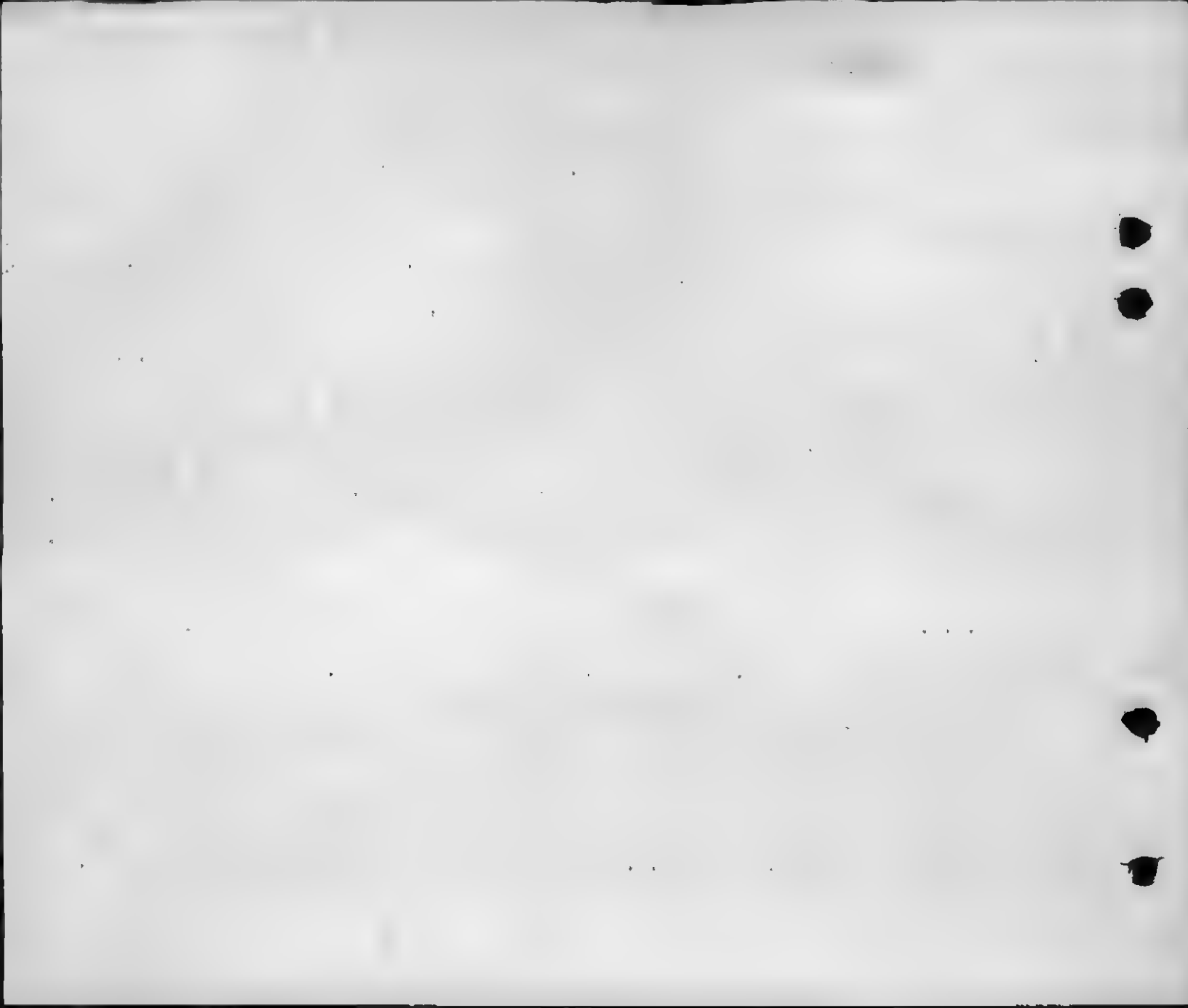
DATE AUG 23 '61

Arthur S. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8988 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

089773



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8989 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08980

1. PLACE OF DEATH a. COUNTY <u>Carroll Co</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>Uniontown Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM EDGAR MAHANNA</u>		DEATH <u>AUGUST 27 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1938</u>
9. AGE (In years last birthday) <u>23</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm laborer &amp; truck driver</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Harver, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>not known</u>		14. MOTHER'S MAIDEN NAME <u>Larima V. Mahanna</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mrs Larima V. Mahanna</u>		Address <u>Keymar, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Fract. Skull - DISLOCATION CERVICAL VERTEBR</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>8/27</u> 19 <u>61</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> <u>Highway</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Westminster</u>		20f. (City or town) (County) (State) <u>Carroll Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/30/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Leisters Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Rural Westminster Md</u>	
23. FUNERAL DIRECTOR <u>L. E. Myers, Jr., Westminster, Md</u>		24a. RECD BY REGISTRAR <u>AUG 31 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
(M)

015

1

0

1

MARYLAND STATE DEPARTMENT OF HEALTH

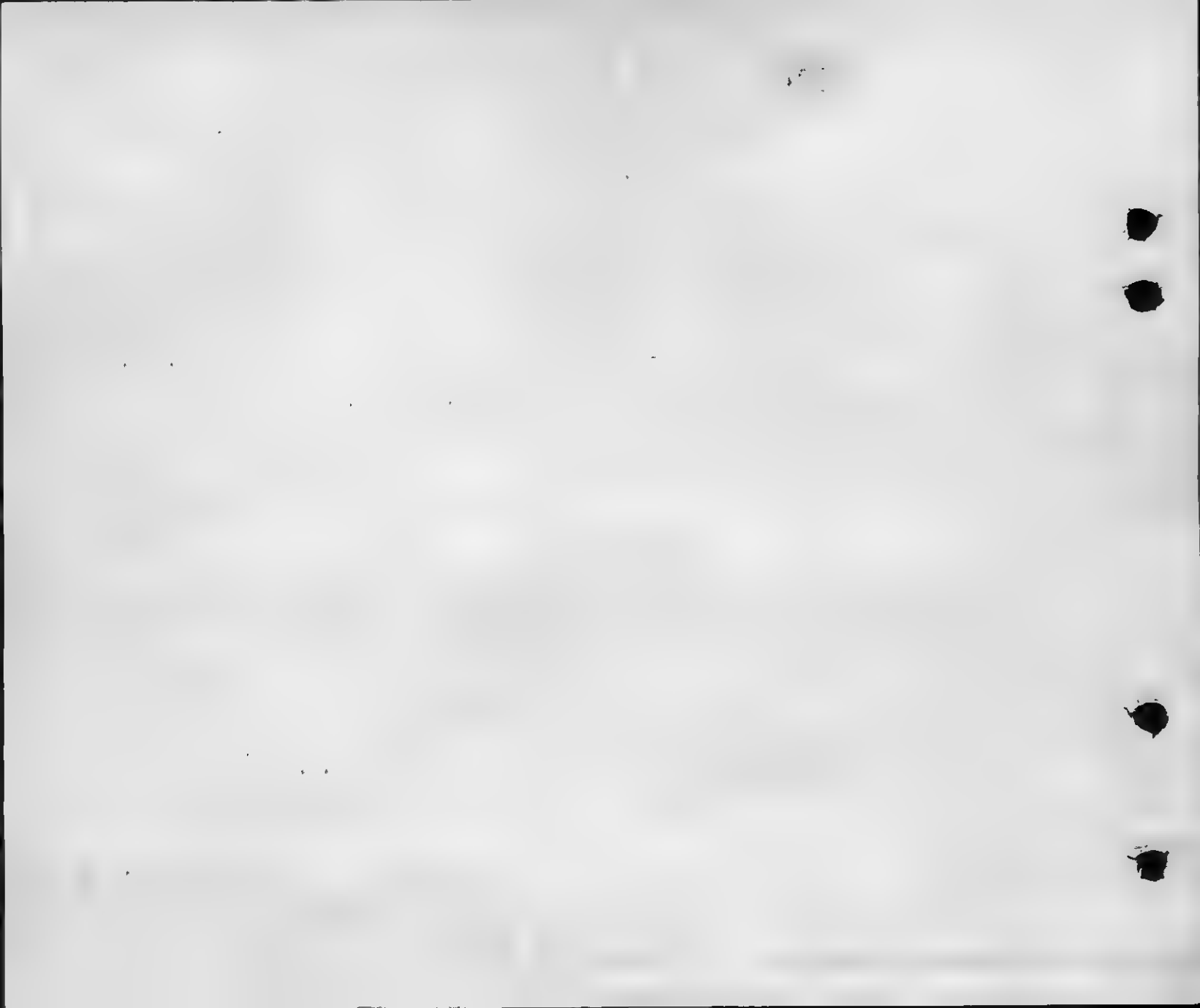
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08981

8990

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3mos. 20dys.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery Co.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>10509 Sweetbriar Parkway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Meropi</b>		First		Middle		Last		4. DATE OF DEATH <b>August 2 1961</b>		Month		Day		Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 1, 1892</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dressmaker &amp; Landlady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Greece</b>		14. MOTHER'S MAIDEN NAME <b>Mary Askitis</b>		Address <b>Springfield Hospital Records</b>							
13. FATHER'S NAME <b>Anestoras Arralios</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b> 600 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pyelonephritis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular disease. Diabetes Mellitus.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>  <b>Weeks</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>4-12-1961</b> to <b>8-2-1961</b> , that (I) (we) last saw the deceased alive on <b>8-2-1961</b> , and that death occurred at <b>12:05 a.m.</b> from the causes and on the date stated above.										22a. SIGNATURE <b>Julian Radzykewycz</b>		22b. DATE SIGNED <b>8-2-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Julian Radzykewycz, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>August 4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>		23d. LOCATION (City, town or county) (State) <b>Riggs Road - Prince Georges Md.</b>		25a. REC'D BY REGISTRAR <b>Arthur Ketter</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur Ketter</b>		DATE <b>AUG 3 '61</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08982

8991

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN 1b <b>34 y. 8 m. 21d.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>--</b>	
3. NAME OF DECEASED (Type or print) First <b>Hallie</b> Middle <b>B.</b> Last <b>McGraw</b>		4. DATE OF DEATH Month <b>8</b> Day <b>10</b> Year <b>19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>unknown</b>
9. AGE (In years last birthday) <b>86?</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jack McGraw</b>		14. MOTHER'S MAIDEN NAME <b>Kratzer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)	
17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>due to septicemia and multiple carbuncles</b> DUE TO (b) <b>1 week</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic Reaction, Catatonic Type</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>at</del> (this hospital) attended the deceased from <b>11/19/ 19 61</b> to <b>8/10/ 19 61</b> , that <del>at</del> (we) last saw the deceased alive on <b>8/10/ 19 61</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Naci N. Buyukunsal, M. D.</b>		22b. DATE <b>8/11/61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Aug/13-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Airy Union</b>		23d. LOCATION (City, town, or county) (State) <b>Sykesville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott J. Munick &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>Aug 15 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>William S. Evans</b>	

(M)

5/5

(1)

MEDICAL CERTIFICATION



TO HOWARD OR ATTENDING PHYSICIAN: The physician requires that the death certificate be executed within 24 hours after death. The physician may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

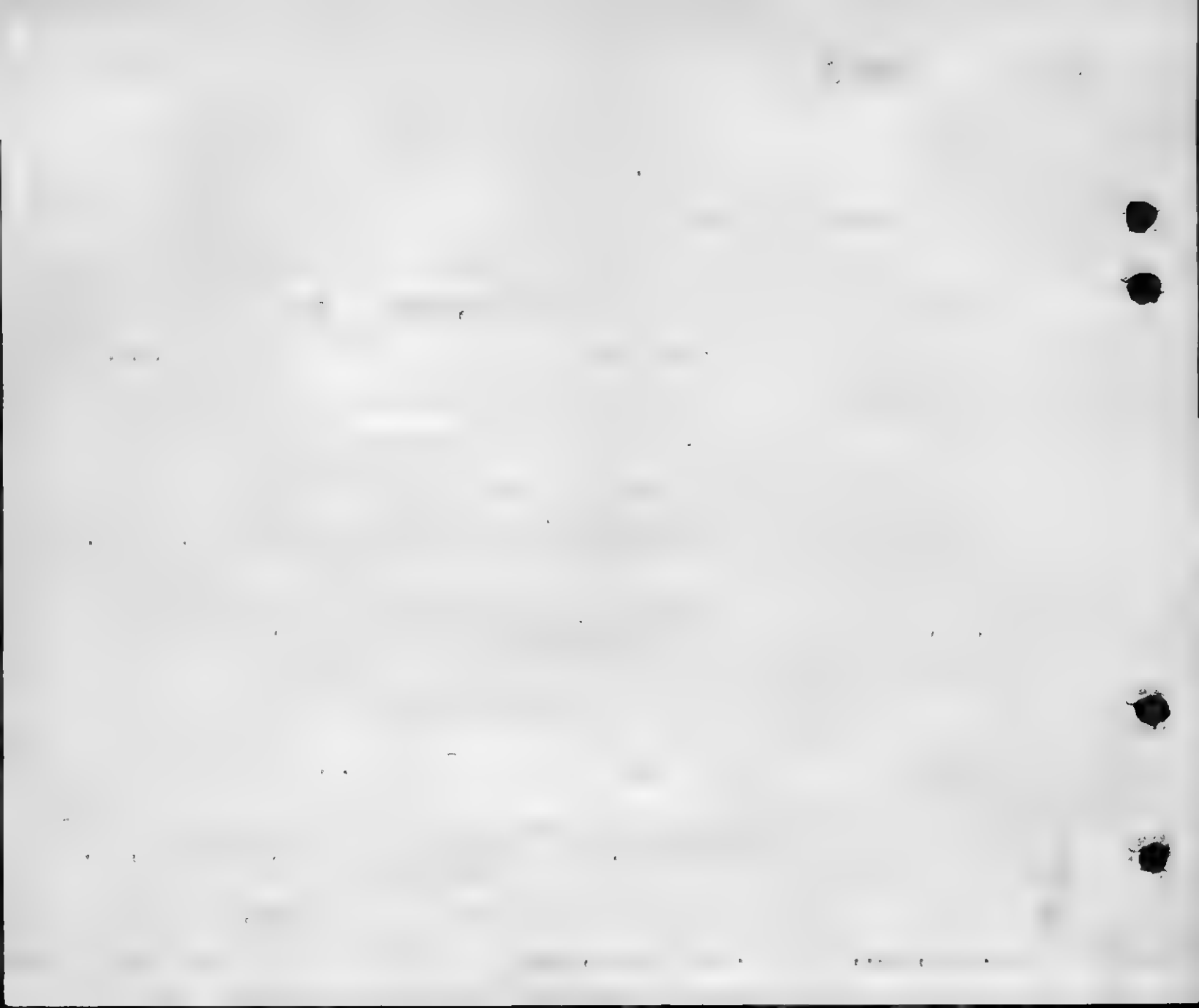
## CERTIFICATE OF DEATH

8992

08983

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN TB <b>2 mos. 8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 2</b> d. STREET ADDRESS <b>909 Wilmet Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Babette Menne</b>		4. DATE OF DEATH <b>August 9 1961</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 23, 1889</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		9. AGE (In years last birthday) <b>72</b>	
11. BIRTH PLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Herman Menne</b>	
14. MOTHER'S MAIDEN NAME <b>Babette Munker</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-1633</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease due to arteriosclerosis.</b> DUE TO (b) <b>Chronic nephrosclerosis due to arteriosclerosis.</b> DUE TO (c) <b>C.B.S. with cerebral arteriosclerosis with psychotic reaction.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield Hospital, Sykesville, Md.</b>	
20f. (City or town) <b>Springfield</b>		20g. (County) <b>Carroll</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>5-31, 1961</b> , to <b>8-9, 1961</b> , that (I) (we) last saw the deceased alive on <b>8-9-1961</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Julian Radzykewycz</b>		22b. DATE SIGNED <b>8-9-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Julian Radzykewycz, M.D.</b>	
22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>		22e. REC'D BY REGISTRAR <b>AUG 14 '61</b>		22f. REGISTRAR'S SIGNATURE <b>Wm. Cook, Inc.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-12-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
23d. LOCATION (City, town or county) <b>Woodlawn, Md</b>		23e. (State) <b>Md</b>		23f. REGISTRAR'S SIGNATURE <b>Wm. Cook, Inc.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</b>		24a. ADDRESS <b>1217 St. Paul Street, Zone 2</b>		24b. DATE <b>AUG 14 '61</b>	

VR A15 (4)  
15M 9/60



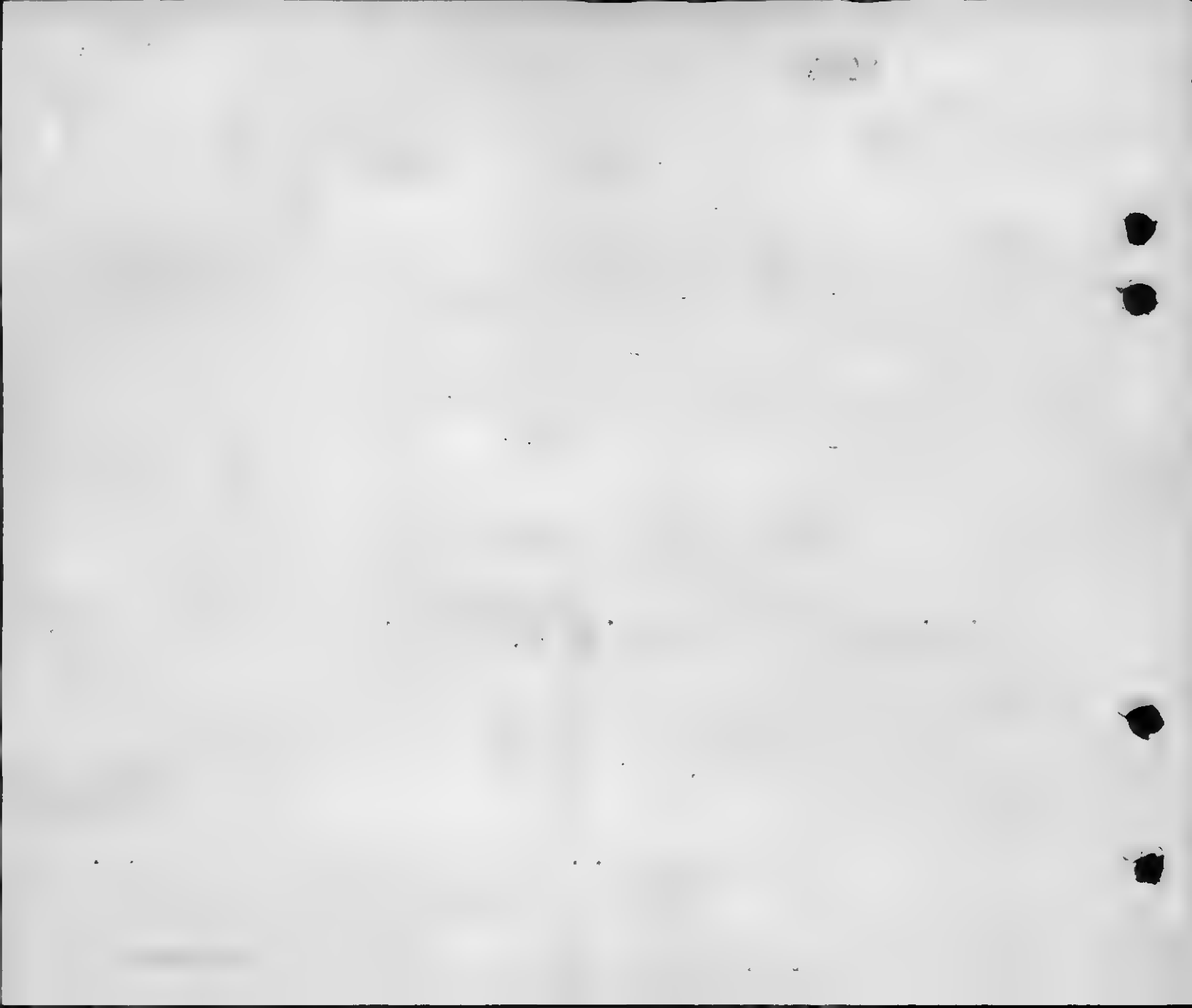
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8993  
CERTIFICATE OF DEATH

18984

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>20 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>-</b>	
3. NAME OF DECEASED (Type or print) <b>Emory Morgan</b>		4. DATE OF DEATH <b>August 3, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>81</b>		10. IF UNDER 1 YEAR: Months <b>81</b> Days <b>3</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>	
13. FATHER'S NAME <b>Napoleon Morgan</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bruchey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address <b>-</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO <b>45 SX</b> Conditions, if any, which gave rise to immediate cause (b) <b>Gangrene of right foot</b> (a), stating the underlying cause last. DUE TO (c) <b>-</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. with senile brain disease. Diabetes Mellitus. Arteriosclerotic cardiovascular disease.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 13, 1961</b> to <b>August 3, 1961</b> that (I) (we) last saw the deceased alive on <b>August 2, 1961</b> and that death occurred at <b>12:25 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Julian Radcykowiez, M.D.</b>		22b. DATE SIGNED <b>8/3/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Julian Radcykowiez, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>8-4-61</b>		23b. DATE THEREOF <b>8-4-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Adm Ananias Bond</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b>		25a. RECD BY REGISTRAR <b>DANUG 7 '61</b>	
ADDRESS <b>Pikes 8 3rd</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	





TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

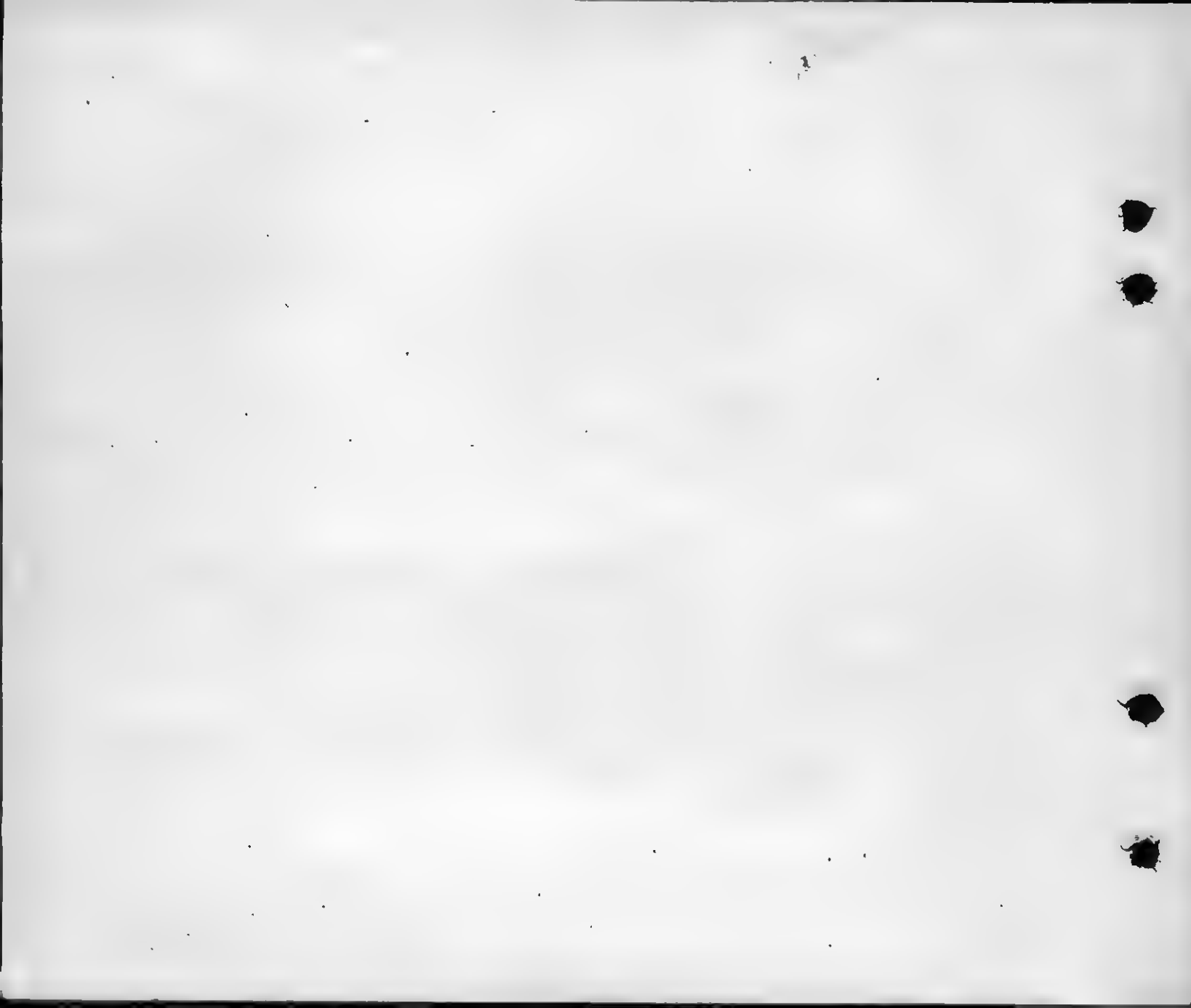
VR A15 (4)  
ISM 9/59

8994

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08985

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hampstead</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA-ALVERTA-MURRAY</u>				4. DATE OF DEATH Month Day Year <u>Aug 17 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 7-1890</u>	
9. AGE (In years lost birthday) <u>71</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hub</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			
13. FATHER'S NAME <u>John T Photeu</u>				14. MOTHER'S MAIDEN NAME <u>Rachel W Shaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>320-34-5792</u>			
17. INFORMANT <u>Everett Murray, Hampstead Md</u>				Address: <u>Hampstead Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 42011 DUE TO <u>Hypertensive Arteriosclerotic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Cardio-Vascular Disease</u> (c) <u>Cardio-Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8-17</u> 1961 to <u>8-17</u> 1961, that (I) (we) last saw the deceased alive on <u>8-17</u> 1961, and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>WH Ford</u> M.D.				22b. DATE SIGNED <u>8/19/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>WH Ford MD</u>				22d. ADDRESS <u>Manchester, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 20-61</u>				23b. DATE THEREOF <u>Aug 20-61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>				23d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>TIPTON-ELINE-Hampstead Md</u>				25a. REC'D BY REGISTRAR <u>Aug 22 61</u>			
25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>							



## 3995

08989

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>8yrs. 8mos. 29days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 23</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>7 N. Carey Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Thomas Naylor</b>		4. DATE OF DEATH Month Day Year <b>August 30, 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 9, 1883</b>		9. AGE (In years, last birthday) <b>78</b> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Street cleaner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Street cleaning</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas Naylor</b>		14. MOTHER'S MAIDEN NAME <b>Bertie Steg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cancer of the lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Months.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with convulsive disorder, associated with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield Hospital, Sykesville, Md.</b>	
20f. (City or town) <b>Sykesville, Carroll Co. Md.</b>		20g. (County) <b>Carroll</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1, 1952</b> , to <b>August 30, 1961</b> , that (I) (we) last saw the deceased alive on <b>August 30, 1961</b> , and that death occurred at <b>2:30 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Agustin del Campo.</b>		M.D. <b>Agustin del Campo, M.D.</b>		22b. DATE <b>8/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-2-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Freedom</b>	
23d. LOCATION (City, town, or county) <b>Sykesville, Carroll Co. Md.</b>		23e. (State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur J. Haight</b>		ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 5 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>C. H. H. H.</b>					



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8996

08987

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admiss.on) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Union Bridge</u>				c. LENGTH OF STAY IN 1b <u>15 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Bridge RD #1</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY MELVIN NULL</u>				4. DATE OF DEATH Month Day Year <u>Aug 28 1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 13 1881</u>	
9. AGE (In years lost birthday) <u>79</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>home - wife</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Immsley</u>				14. MOTHER'S MAIDEN NAME <u>Annan Immsley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mrs Hilda M. Margouette, same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio Vascular</u>							
DUE TO (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan - 1961</u> to <u>Aug 28</u> , 1961, that (I) (we) last saw the deceased alive on <u>Aug 27</u> , 1961, and that death occurred at <u>8</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>James T. Marsh</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>8/28/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>				22d. ADDRESS <u>Westminster Md</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE THEREOF <u>8/31/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kraders Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rural Westminster Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>				25a. REC'D BY REGISTRAR <u>Arthur L. Hanna</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	
ADDRESS <u>Westminster Md.</u>				DATE <u>AUG 31 '61</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 5221 9/11/61 mh

8997

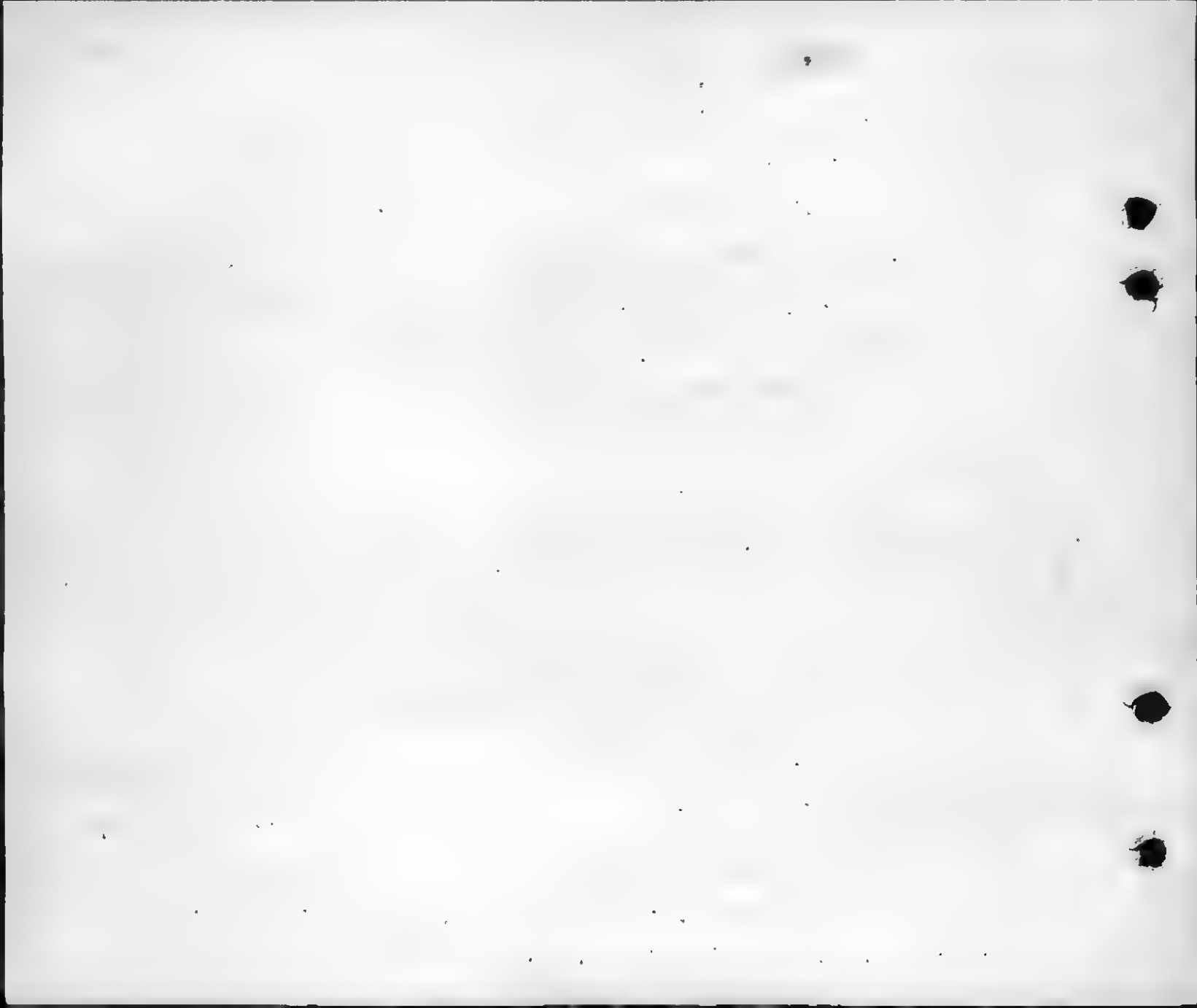
## CERTIFICATE OF DEATH

Reg. Dist. No.

08988

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN lb <u>2 1/2 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Golden Age Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> d. STREET ADDRESS <u>Temple</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Plunkert, Margaret</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>Wh</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>12-4-05</u> 9. AGE (In years last birthday) <u>55</u> 10. IF UNDER 1 YEAR Months Days Hours Min		4. DATE OF DEATH <u>Aug 31 1961</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>X</u> 11. BIRTHPLACE (State or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>X</u>			
13. FATHER'S NAME <u>David S. Plunkert</u>		14. MOTHER'S MAIDEN NAME <u>Laura ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>213-03-6448</u> INFORMANT Address <u>Loretta A. Freburger</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260k Cerebral Thrombosis</u> DUE TO (b) <u>Cardiovascular Disease</u> DUE TO (c) <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>Chronic</u> <u>Chronic</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>No</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>X</u> 19 <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u> 20f. (City or town) <u>X</u> (County) (State)	
21. I certify that I attended the deceased from <u>8-25-1961</u> to <u>8-31-1961</u> that I last saw the deceased alive on <u>8-30</u> , 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Stone</u> M.D. <u>W. C. Stone</u> <u>MD</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>W. C. STONE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/2/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Howard H. Hubbard 4107 Wilkens Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 5 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**8998**

**08989**

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>			c. LENGTH OF STAY IN 1b <b>12yr.8mo.22days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> <b>3V01-4</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>412 W. Henrietta St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>E.</b> Last <b>PRIDHAM</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>18</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-1-1863</b>	
9. AGE (In years last birthday) yrs <b>98</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>David Wyble</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis, simple deterioration.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>  <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11-26</b> , 19 <b>48</b> , to <b>8-18</b> , 19 <b>61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8-18</b> , 19 <b>61</b> , and that death occurred at <b>3:30 A.</b> from the causes and on the date stated above							
22a. SIGNATURE <i>[Signature]</i> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8-18-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ilse Karm, M. D.</b>				22d. ADDRESS <b>Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8.23.61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem</b>		23d. LOCATION (City, town, or county) (State) <b>Bato Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>McCully 130 E Fort Ave</b>				ADDRESS <b>Balto 35 Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 22 '61</b>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION



TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**8999**

**08990**

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float:right">MARYLAND</span>				<b>2 USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Millers</u>		c. LENGTH OF STAY IN 1b <u>52</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME DECEASED</b> (Type or print) First <u>Elizabeth</u> Middle <u>K</u> Last <u>SABANIA SANDRACK</u>				<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>6</u> Year <u>1961</u>			
<b>5 SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Aug 15-1881</u>	<b>9. AGE</b> (In years last birthday) <u>79</u> yrs	<b>IF UNDER 1 YEAR</b> Months <u>—</u> Days <u>—</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>York County, Pa</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>Samuel Cornbower</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Caroline Garbick</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO</b> <u>274-14-0488</u>		<b>17. INFORMANT</b> Address <u>Mrs. George H. Wagner, Abbeville, Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Carcinoma of Uterus</u> 174x DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>Cerebral Hemorrhage</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 yrs -</u> <u>5 yrs -</u> <u>15 mths.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>19</u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Aug 5</u> <u>1961</u> , to <u>Aug 6</u> <u>1961</u> , that (we) last saw the deceased alive on <u>Aug 5</u> <u>1961</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>W. H. Foard</u>		<b>22b. DATE SIGNED</b> <u>8/6/61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>W. H. Foard. M.D.</u>			
<b>22d. ADDRESS</b> <u>Manchester, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Aug 9/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Manchester</u>			
<b>23d. LOCATION (City, town, or county)</b> <u>Carroll Co Md</u>		<b>23e. (State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tipton-Elmer</u>		<b>24b. ADDRESS</b> <u>Hampstead Md</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>AUG 9 61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Evans</u>							

**(M)**

**(I)**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

9000

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08991

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3 mos. 27 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>25 Wayne Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Dorothy Featherstone Santmyers</b>		First		Middle		Last		4. DATE OF DEATH Month <b>August</b>		Day <b>9</b>		Year <b>1961</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 4, 1889</b>		9. AGE (in years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months <b>72</b>		IF UNDER 24 HRS. Days <b>72</b>		Hours <b>72</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (Country & State, or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>													
13. FATHER'S NAME <b>Harry Featherstone</b>		14. MOTHER'S MAIDEN NAME <b>Clara Holt</b>																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-34-8350-D</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>-</b> (c) <b>-</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with cerebral arteriosclerosis.</b>												INTERVAL BETWEEN ONSET AND DEATH Years <b>-</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
21. I certify that (I) (this hospital) attended the deceased from <b>4-12-1961</b> to <b>8-9-1961</b> , that (I) (we) last saw the deceased alive on <b>8-9-1961</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>Naci B. Buyukunsal, M.D.</b>												22b. DATE SIGNED <b>8-9-61</b>							
22c. PHYSICIAN'S NAME (Type) <b>Naci B. Buyukunsal, M.D.</b>												22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>8/12/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) <b>Montgomery County, Md.</b>		(State)											
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>												25. REC'D BY REGISTRAR <b>Washington 9, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>					



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

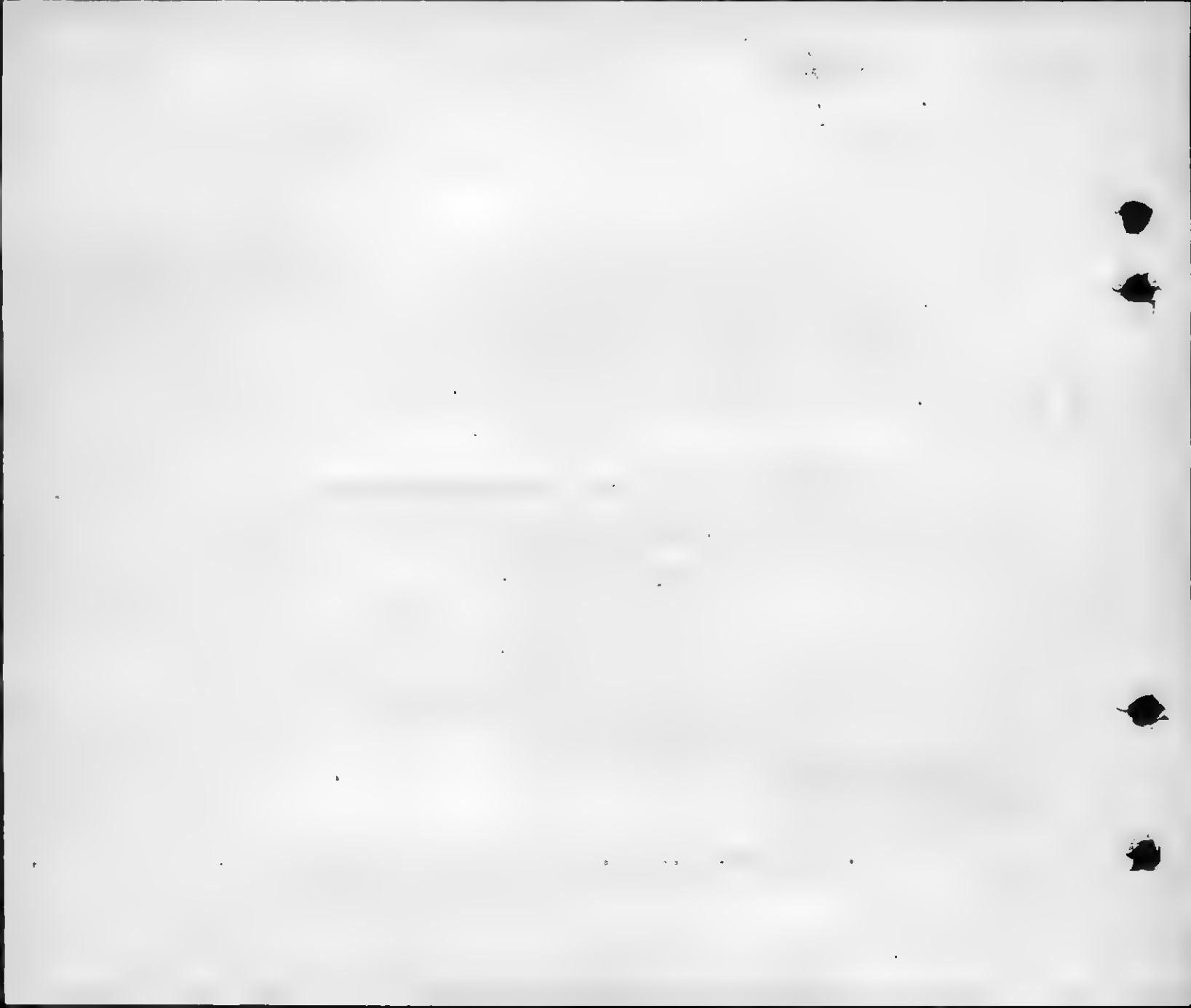
**9001**

**18982**

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - SYKESVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - SYKESVILLE, MD.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GOLDEN AGE NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle Last <b>Selby</b>				4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-12-1878</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Seamstress</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Johnna Selby</b>				14. MOTHER'S MAIDEN NAME <b>Rachel Kelley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>AC</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>—</b>			
17. INFORMANT <b>Mr Albert Selby - Sykesville, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>20 Yrs.</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>20 Yrs.</b>							
(c) <b>ADVANCED SENILE CHANGES</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1935</b> to <b>1 August</b> , 19 <b>61</b> , that (i) (we) last saw the deceased alive on <b>1 August</b> , 19 <b>61</b> , and that death occurred at <b>8:45 PM</b> , the causes and on the date stated above							
22a. SIGNATURE <b>Wm. H. Lawson, Jr.</b>				22b. DATE SIGNED <b>8/1/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Wm. H. Lawson, Jr., M.D.</b>				22d. ADDRESS <b>Liberty Rd at Eldersburg, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westley Freedom</b>		23d. LOCATION (City, town, or county) (State) <b>CARROLL County MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur W. Knight</b>				25a. REC'D BY REGISTRAR <b>AUG 7 '61</b>			
ADDRESS <b>Sykesville, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

9002

08993

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. LENGTH OF STAY IN 1b <u>25 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>187 Washington Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM CARROLL SHACK</u>				4. DATE OF DEATH Month Day Year <u>Aug. 26 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 29, 1910</u>	
9. AGE (In years lost birthday) <u>50</u> yrs		10. UNDER 1 YEAR Months Days Hours Min		11. UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Salesman Carroll Distributors</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Ind U.S.A.</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>William N. Shack</u>				14. MOTHER'S MAIDEN NAME <u>Eliza J. Barber</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes World War II</u>				16. SOCIAL SECURITY NO. <u>7-22-100000</u>			
17. INFORMANT <u>Mrs. Roger T. Brown, Westminster, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Liver (metastatic)</u> 156.1 DUE TO <u>Site undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anemia; Cachexia</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1961</u> to <u>Aug 26, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 21, 1961</u> , and that death occurred <u>10:25 PM</u> from the causes and on the date stated above							
22a. SIGNATURE <u>William Speicher</u> M.D.				22b. DATE SIGNED <u>8/28/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Westminster, Md.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 29/61</u>				23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Church Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Rural Westminster, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>				25a. REC'D BY REGISTRAR <u>AUG 31 '61</u>			
ADDRESS <u>Westminster, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

bp



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

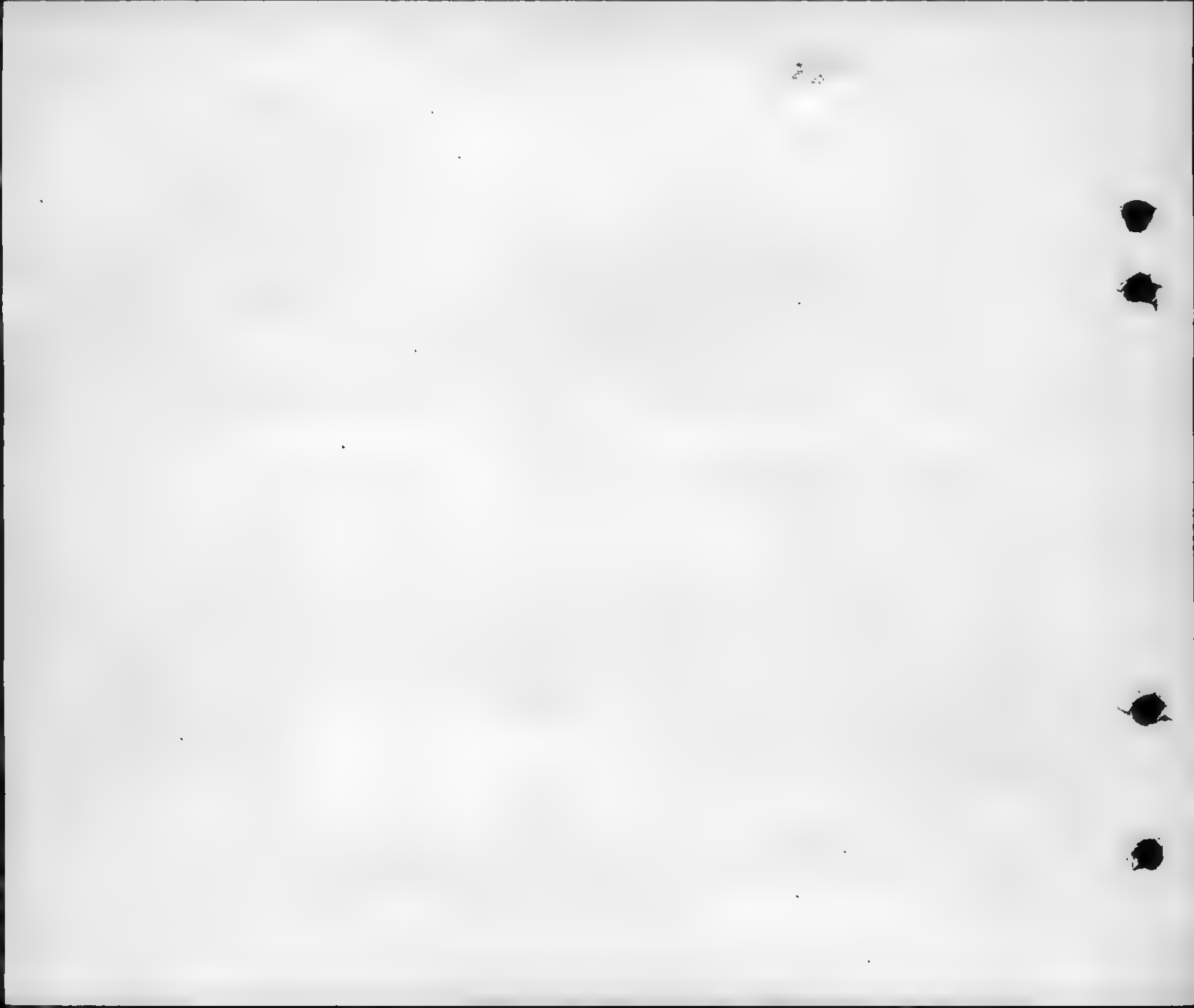
1

9003

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08994

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Schicksville</i>		c. LENGTH OF STAY IN <i>2 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pullen Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Chicksbury</i>	
f. STREET ADDRESS <i>Green Park Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARY BELLE SIMON</i>		4. DATE OF DEATH <i>August 27 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 3, 1882</i>
9. AGE (In years lost birthday) <i>79</i> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Beattie</i>		14. MOTHER'S MAIDEN NAME <i>Emma Cunningham</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs. B. Simon</i>		Address <i>Above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Craney Thrombosis, Arteriosclerosis</i> DUE TO <i>generalized, Arteriosclerotic Heart Dis.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Hypertension, C.V.A. + Parkinson Dis.</i> (b) <i>—</i> (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>9-26-58</i> <i>8-27-61</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>9-26 1958</i> to <i>8-27 1961</i> , that (I) (we) last saw the deceased alive on <i>8-27 1961</i> , and that death occurred at <i>11:45 p.m.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Howard E. Hall</i>		22b. DATE SIGNED <i>29 Aug 61</i>	
22c. PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		22d. ADDRESS <i>SYKESVILLE, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>8-30-61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Turney Ridge</i>	23d. LOCATION (City, town, or county) (State) <i>Pikesville, Balt. Co., Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur A. Haight</i>		25a. REC'D BY REGISTRAR <i>SEP 1 '61</i>	
ADDRESS <i>Sykesville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>	







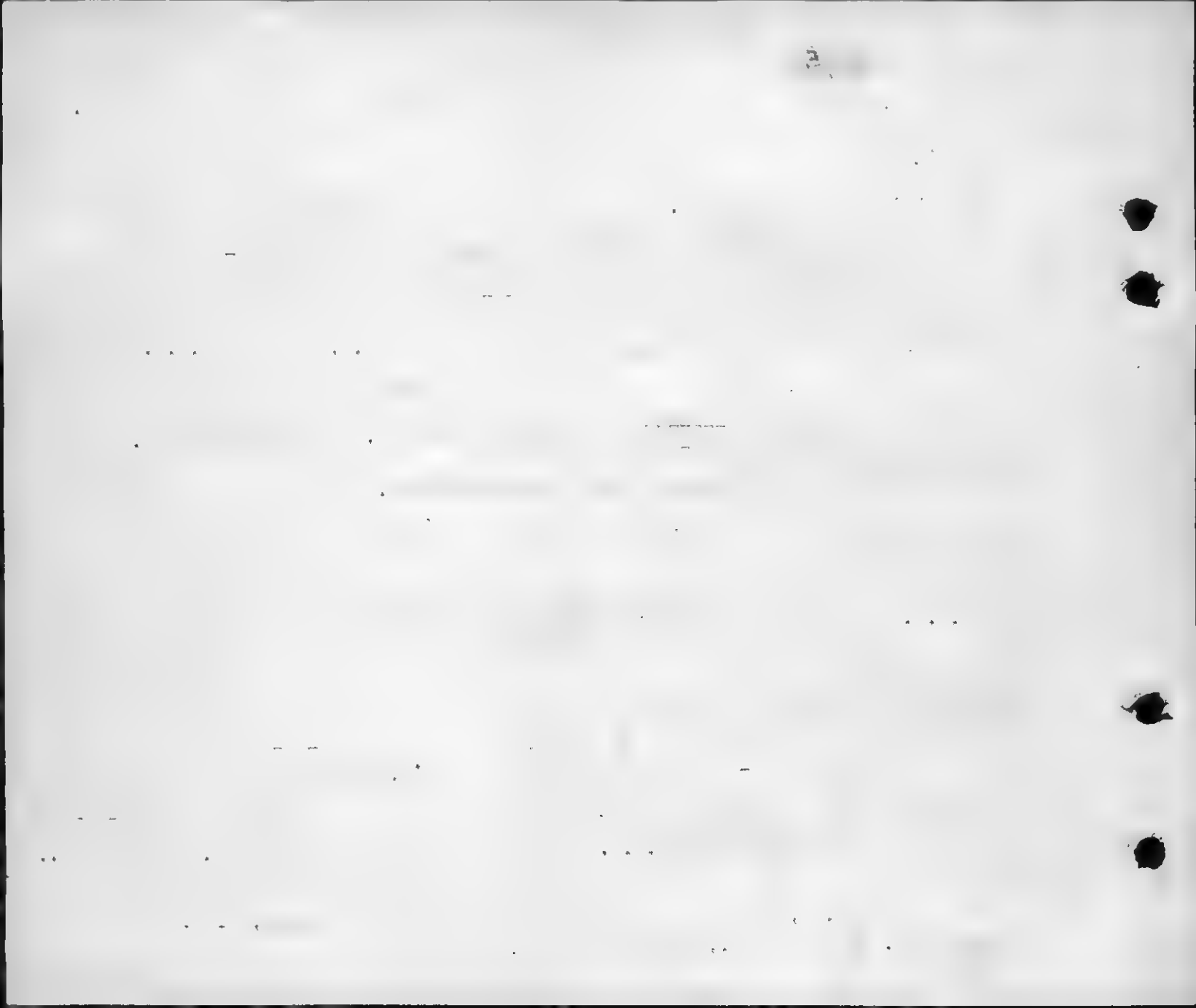
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
9005  
CERTIFICATE OF DEATH

08996

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery Co.</b> 15 ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
3 NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>George</b> Last <b>Stecher</b>		4. DATE OF DEATH Month <b>8</b> Day <b>26</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-4-1887</b>
9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown - Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Law Books</b>	
11 BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Stecher</b>		14 MOTHER'S MAIDEN NAME <b>Mary Bauer</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b> <b>577-03-4112</b>	
17 INFORMANT <b>Hospital records.</b>		Address <b>Sykesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease.</b> <b>1420</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. due to cerebral arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>8-17</b> to <b>8-26</b> , that (I) (we) last saw the deceased alive on <b>8-26</b> , 19 <b>61</b> , and that death occurred at <b>4:25</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo.</b> M.D.		22b. DATE SIGNED <b>8-26-1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 28, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc., Silver Spring, Md.</b> <b>Raymond A. Ziska</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 29 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Clara P. H. ...</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. Page 4  
may be filed by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

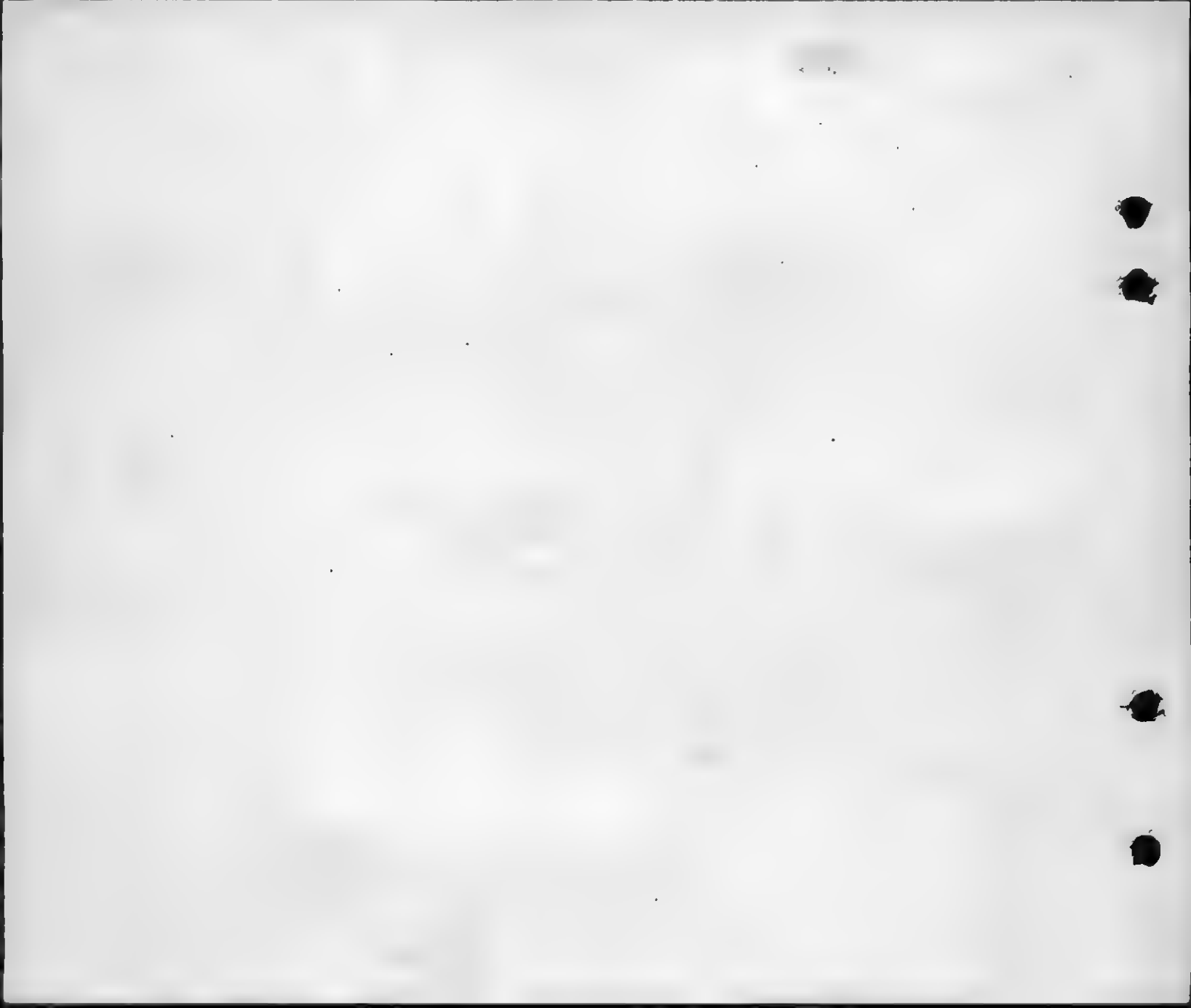
9006

CERTIFICATE OF DEATH

Item 6 - Film 9-94 9/25/61 iwh

08997

1 PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYkesville - Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYkesville - Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pine Knob Road</b>		d. STREET ADDRESS <b>Pine Knob Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Gertrude R. Stout</b>		4. DATE OF DEATH Month Day Year <b>August 24 1961</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11-25-1878</b>
9. AGE (In years last birthday) <b>82</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Fross</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Linton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT Address <b>MRS. Elizabeth Parks - Baltimore, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO <b>Ch. heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis, Generalized Atherosclerosis</b> DUE TO (c) <b>10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>8.17.1961</b> to <b>8.24.1961</b> , that (I) (we) last saw the deceased alive on <b>8.19.1961</b> , and that death occurred at <b>6:25</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Sani Okutman</b>		22b. DATE <b>8.25.61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Sani Okutman</b>		22d. ADDRESS <b>Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-26-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Freedom</b>		23d. LOCATION (City, town, or county) (State) <b>CARROLL Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Luther H. Haight</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 28 '61</b>	
ADDRESS <b>Sykesville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Orlana S. Hume</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or in any event within 72 hours after death.

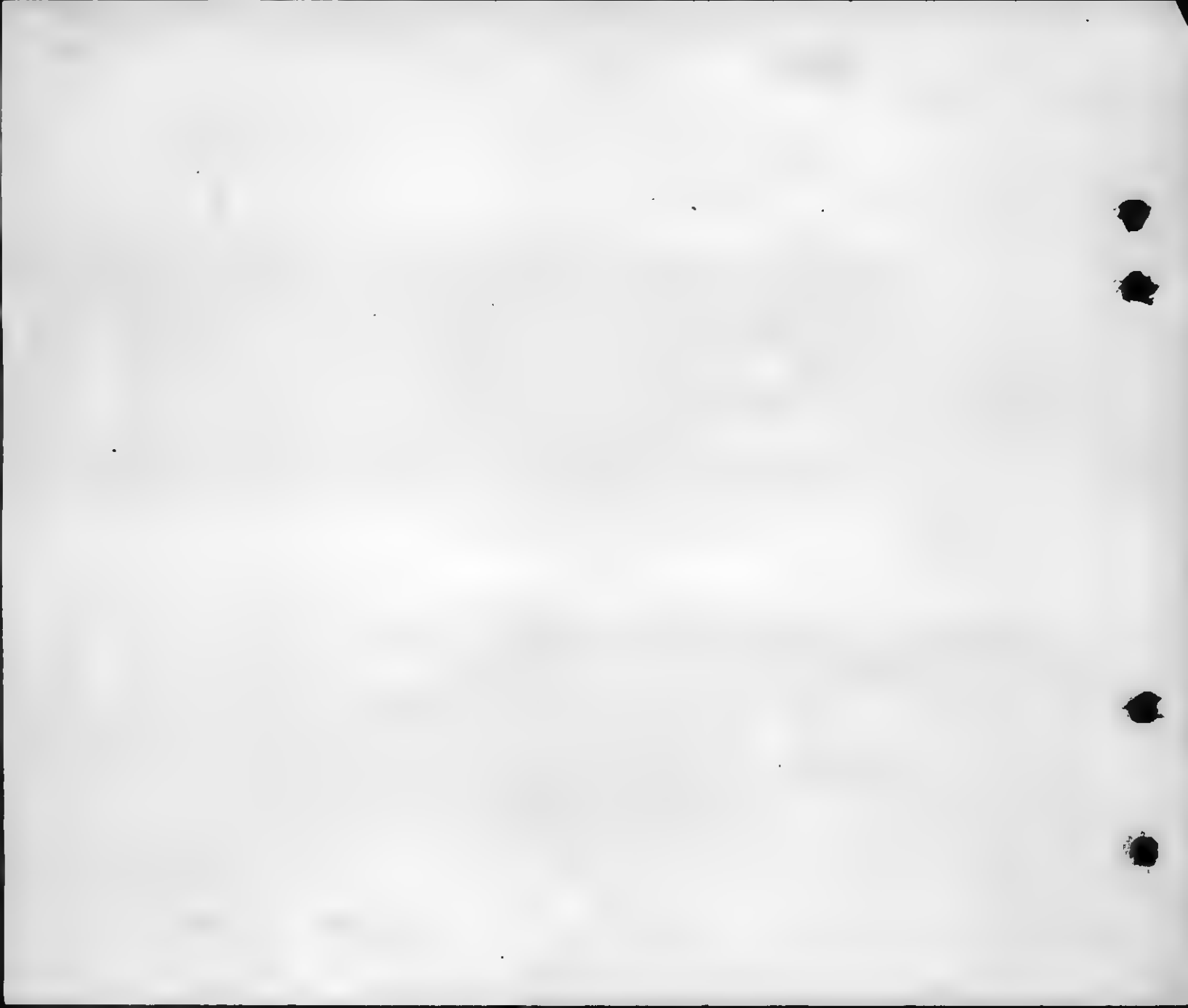
VR A15 (4)  
15M 11/59

1  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

9007

08998

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>60 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>120 E. Green St.</u>		e. STREET ADDRESS <u>1120 E. Green St.</u>	
3. NAME OF DECEASED (Type or print) <u>LILLIAN LOUISE TAWNEY</u>		4. DATE OF DEATH <u>Aug. 27 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4 1891</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Reese, Carroll Co.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Louis Mancha</u>	
14. MOTHER'S MAIDEN NAME <u>Louise Raffle</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Francis T. Tawney, Westminster Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> 450 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - Generalized</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-18</u> 19 <u>61</u> , to <u>8-27</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8-26</u> 19 <u>61</u> , and that death occurred at <u>11 P.</u> M. from the causes and on the date stated above			
22a. SIGNATURE <u>James J. Marshall</u>		22b. DATE SIGNED <u>8/28/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>		22d. ADDRESS <u>Westminster Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/30/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Leister Church Cemetery Rural Westminster Md.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster Md.</u>		25a. REC'D BY REGISTRAR <u>Aug 31 '61</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9008

08999

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> <span style="float: right;">Months <u>2 1/2</u></span> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Carroll</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md. Rt. 5 Box 36</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <u>Mary Beryl Warehime</u>			<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>4</u> Year <u>19 61</u>				
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>October 6, 99</u>			
<b>9. AGE</b> (In years last birthday) <u>61</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND Maryland USA</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			<b>13. FATHER'S NAME</b> <u>Charles Mitten</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>Ann Arnold</u>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				
<b>16. SOCIAL SECURITY NO.</b> <u>24-42-1905</u>			<b>17. INFORMANT</b> <u>Springfield Records (Hospital)</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent C.V.A.</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Circulatory disturbance, Cerebral arteriosclerosis--Diabetes Mellitus</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>a.m.</u> <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) (City or town) _____ (County) _____ (State) _____			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>May 26, 1961</u> , 19____, to <u>August 4</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>August 4</u> , 19 <u>61</u> , and that death occurred <u>at 11:20 P.M.</u> on the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Julian Radcykowsky, M.D.</u>				<b>22b. DATE SIGNED</b> <u>August 5, 1961</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Julian Radcykowsky, M.D.</u>				<b>22d. ADDRESS</b> <u>Springfield State Hospital, Sykesville, Md</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>AUG 8-1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>KRIDERS</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. J. Sharpley</u>		<b>24b. ADDRESS</b> <u>New Windsor</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>AUG 8 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Huns</u>				<b>25c. REGISTRAR'S NAME</b> <u>Arthur S. Huns</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

02230

8000

(M)

(1)

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10-15-91 BY SP-6  
JANUARY 1991

1  
FOR STATE  
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09000

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>				c. LENGTH OF STAY IN <b>1</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D. 1</b>				d. STREET ADDRESS <b>R. D. 1</b>			
3. NAME OF DECEASED (Type or print) <b>HARVIE</b>				4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 3 1906</b>	
9. AGE (In years last birthday) <b>54</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Engineer</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>517-14-1715</b>		17. INFORMANT <b>Betty Wilson Finksburg Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombosis of Right Coronary Artery</b> DUE TO (c) <b>Arteriosclerotic Heart Disease.</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				22b. DATE THEREOF <b>Aug-14/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>	
23. FUNERAL DIRECTOR <b>J. F. Eline, Sns Ruststown Md</b>				22d. LOCATION (City, town, or country) <b>Baltimore Md</b>		24a. REC'D BY REGISTRAR <b>AUG 17 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Petty</b>			

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000